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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02425

2451

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie</u>		<u>33 yrs</u>		TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>200 Second Ave, S.W.</u>				STREET ADDRESS (If rural give location) <u>200 Second Ave, S.W.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Alfred</u> (Middle) <u>Frederick</u> (Last) <u>Adams</u>				(Month) <u>March</u> (Day) <u>8</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 4, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A-S Abell Co</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas W. Adams</u>				14. MOTHER'S MAIDEN NAME <u>Laura V. Webb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-2985A</u>		17. INFORMANT & ADDRESS <u>Mrs. Elizabeth Adams 200 Second Ave Glen Burnie</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage.</u>						<u>5 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-Vascular Disease</u>						<u>2 1/2 years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>53</u> , to <u>March 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 8</u> , 19 <u>56</u> , and that death occurred at <u>7:58 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Anna S. Beallingshield</u>				DATE SIGNED <u>March 14, 1956</u>			
ADDRESS (Street, city, town, state) <u>108 Central Ave. Glen Burnie Md 9</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 13, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		LOCATION (City, town, or county) <u>Baltimore Co., Md.</u>	
24. REC'D BY REGISTRAR <u>L. J. Dealba</u>		REGISTRAR'S SIGNATURE <u>L. J. Dealba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Phingleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
DATE <u>March 14, 1956</u>							

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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02427

2462 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Puerto Rico</u> COUNTY <u>---</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u> <u>Ft. Geo G. Meade, Md.</u>		LENGTH OF STAY (in this place) <u>7 Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>San German</u>		<u>89X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>Minillas Valle</u>			
3. NAME OF DECEASED (Type or Print) <u>ANGELA</u> (First) <u>AIMODOVAR</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>March 12 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12, March 1956</u>	9. AGE last birthday yrs. <u>2</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min. <u>2 18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis D. Almodovar</u>				14. MOTHER'S MAIDEN NAME <u>Luz A. Ponce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mother, 2931 N. Calvert Street, Baltimore, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>773.5 IMMEDIATE CAUSE (A) Respiratory Failure</u> ANTECEDENT CAUSE(S) DUE TO <u>Prematurity</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>---</u> STATING UNDERLYING CAUSE LAST. (C) <u>---</u>				2 hrs 18 min			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 12, 1956</u> , to <u>March 12, 1956</u> , that I last saw the deceased alive on <u>March 12, 1956</u> , and that death occurred at <u>1846 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George Norman Schultz, M.D.</u>				ADDRESS (Street, city, town, state) <u>Ft. Geo. G. Meade, Md.</u> DATE SIGNED <u>12 Mar 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>13 Mar 56</u>		NAME OF CEMETERY OR CREMATORY <u>Removed to Medical Lab.</u>		LOCATION (City, town, or county) (State) <u>Ft. Geo. G. Meade, Md.</u>	
24. REC'D BY REGISTRAR <u>W.I. Saylor</u>		REGISTRAR'S SIGNATURE <u>W.I. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>None</u>		ADDRESS	
DATE <u>14 March 56</u>		REGISTRAR'S SIGNATURE <u>W.I. Saylor, 1st Lt, MSC</u>		None			

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RECEIVED
BUREAU OF VITAL RECORDS
MAY 16 1936

THIS CERTIFICATE OF DEATH IS A STATUTORY REQUIREMENT OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS A PUBLIC DOCUMENT AND IS NOT TO BE DESTROYED. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO IS THE OFFICIAL AUTHORITY FOR THE ISSUANCE OF THIS CERTIFICATE. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO IS THE OFFICIAL AUTHORITY FOR THE ISSUANCE OF THIS CERTIFICATE.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

08433

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES	
JAMES H. HARRIS		Male		45		Jan 15, 1891		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		10:30 AM		J. H. Harris		J. H. Harris		J. H. Harris	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. NAME OF MINISTER		17. NAME OF CHURCH		18. NAME OF FUNERAL HOME		19. NAME OF CEMETERY		20. NAME OF BURIAL		21. NAME OF CREMATION		22. NAME OF URN		23. NAME OF CASK		24. NAME OF COFFIN	
St. Paul's Episcopal Church		St. Paul's Episcopal Church		Jan 15, 1936		J. H. Harris		St. Paul's Episcopal Church		J. H. Harris		St. Paul's Episcopal Church		St. Paul's Episcopal Church		St. Paul's Episcopal Church		St. Paul's Episcopal Church		St. Paul's Episcopal Church		St. Paul's Episcopal Church	

BUREAU V. 3

MAY 16 1936

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2463 **CERTIFICATE OF DEATH**

02428

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Puerto Rico</u> COUNTY <u>—</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Geo G. Meade, Md.</u>		<u>7 Months</u>		TOWN <u>San German</u>		<u>89X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 U. S. Army Hospital</u>				<u>Minillas Valle</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>INES MARIA ALMODOVAR</u>				<u>March 12 19 56</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Single</u>		<u>March 12, 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Louis D. Almodovar</u>				<u>Luz A. Ponce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>None</u>		<u>Mother 2031 N. Calbert Street, Baltimore, Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
773.5 IMMEDIATE CAUSE (A)				<u>Respiratory Failure</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Prematurity</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
						<u>2 hrs 29 min</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 12, 19 56</u> , to <u>March 12, 19 56</u> , that I last saw the deceased alive on <u>March 12, 19 56</u> , and that death occurred at <u>1850 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George Norman Schultz</u>				ADDRESS (Street, city, town, state) <u>Fort Geo. G. Meade, Maryland</u>			
DATE <u>14 Mar 56</u>				DATE SIGNED <u>12 Mar 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>13 Mar 56</u>		<u>Removed to Medical Lab.</u>		<u>Ft. George G. Meade, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>WILLIAM L. SAYLOR, 1ST LT MSC</u>		<u>None</u>			

215024/220

CERTIFICATE OF DEATH

Ref. Div. No. 21

DECEASED'S NAME (Print or Write)

MARYLAND

ALBANY

DATE OF DEATH (Print or Write)

1936

1936

1936

PLACE OF DEATH (Print or Write)

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CAUSE OF DEATH (Print or Write)

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CAUSE OF DEATH (Print or Write)

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PLACE OF DEATH (Print or Write)

BUREAU V. S.

MAR 16 1936

RECEIVED

1. This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the State Department of Health, Baltimore, Maryland. It is to be filled out in duplicate, and the original is to be filed in the office of the State Department of Health, Baltimore, Maryland. The duplicate is to be filed in the office of the local health officer, or the coroner, or the physician, or the person who has charge of the body. It is to be filled out in duplicate, and the original is to be filed in the office of the State Department of Health, Baltimore, Maryland. The duplicate is to be filed in the office of the local health officer, or the coroner, or the physician, or the person who has charge of the body. It is to be filled out in duplicate, and the original is to be filed in the office of the State Department of Health, Baltimore, Maryland. The duplicate is to be filed in the office of the local health officer, or the coroner, or the physician, or the person who has charge of the body.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02429

2464

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Crownsville		2yrs.7mos.13days		TOWN Baltimore City		3 Vol-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) 1502 Whitelock Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Elizabeth (Middle) (Last) Anderson				(Month) 3 (Day) 6 (Year) 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	Negro	Widow	5/9/86	69 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Domestic		---		Maryland		U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joshua Reid				Anna Chase			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		Unk.		Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
430.1 IMMEDIATE CAUSE (A) Coronary Thrombosis							
ANTECEDENT CAUSE(S) DUE TO (B) HACVD						2 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome associated with Arteriosclerosis							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
---		---					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>		---		---		---	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
---		M.		---			
22. I hereby certify that I attended the deceased from 7/5 , 19 55 , to 3/6 , 19 56 , that I last saw the deceased alive on 3/6 , 19 56 , and that death occurred at 12 Noon , from the causes and on the date stated above.							
SIGNATURE Wesley W. Cadenhead				ADDRESS (Street, city, town, state) Crownsville, Md.		DATE SIGNED 3/6/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
---		3/9/56		Mt. Auburn		Balto, City	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
March 9, 1956		J. W. Gray		Rev. L. Nelson		1345 N. Lombard	

BUREAU V. S.

1956 9 MAR 2

RECEIVED

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INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2465

CERTIFICATE OF DEATH

02430

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>P.A.Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Green Gables (Pasadena Rfd)</u>		<u>3 yrs.</u>		TOWN <u>Green Gables (Pasadena Rfd)</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 1 - Box 49</u>				STREET ADDRESS (If rural give location) <u>Route 1 - Box 49</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>Hripsima</u>		(Middle) <u>Azhderian</u>		(Last)		(Day) (Year)	
(Type or Print)				<u>March 16</u>		<u>1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. CITIZEN OF WHAT COUNTRY?		
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>March 20, 1880</u>	<u>75</u> yrs.	<u>TURKEY</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Own Home</u>		<u>Turkey</u>		<u>TURKEY</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Paul Cynejian</u>				<u>Mariam Tirajian</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Garobed Azhderian Pasadena Md. Rt. 1 - Box 51</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>Cerebral hemorrhage</u>				<u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>none</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 12, 1956</u>, to <u>March 16, 1956</u>, that I last saw the deceased alive on <u>March 15, 1956</u>, and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>R. M. McLaughlin</u>		<u>March 19, 1956</u>		<u>Glen Haven</u>		<u>Glen Burnie Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		<u>L. J. Dealba</u>		<u>R. M. McLaughlin</u>		<u>Glen Burnie, Md.</u>	
DATE		REGISTRAR'S SIGNATURE		DATE		ADDRESS	
<u>Mar. 20, 1956</u>							

CERTIFICATE OF DEATH

1. Usual Residence (House or Apartment)

2. Date of Death

3. Place of Death

4. Age

5. Sex

6. Race

7. Occupation

8. Cause of Death

9. Date of Death

10. Place of Death

11. Age

12. Sex

13. Race

14. Occupation

15. Cause of Death

16. Date of Death

17. Place of Death

18. Age

19. Sex

20. Race

21. Occupation

22. Cause of Death

23. Date of Death

24. Place of Death

25. Age

26. Sex

27. Race

28. Occupation

29. Cause of Death

30. Date of Death

31. Place of Death

32. Age

33. Sex

34. Race

35. Occupation

36. Cause of Death

37. Date of Death

38. Place of Death

39. Age

40. Sex

41. Race

42. Occupation

43. Cause of Death

44. Date of Death

45. Place of Death

46. Age

47. Sex

48. Race

49. Occupation

50. Cause of Death

51. Date of Death

52. Place of Death

53. Age

54. Sex

55. Race

56. Occupation

57. Cause of Death

58. Date of Death

59. Place of Death

60. Age

61. Sex

62. Race

63. Occupation

64. Cause of Death

65. Date of Death

66. Place of Death

67. Age

68. Sex

69. Race

70. Occupation

71. Cause of Death

72. Date of Death

73. Place of Death

74. Age

75. Sex

76. Race

77. Occupation

78. Cause of Death

79. Date of Death

80. Place of Death

81. Age

82. Sex

83. Race

84. Occupation

85. Cause of Death

86. Date of Death

87. Place of Death

88. Age

89. Sex

90. Race

91. Occupation

92. Cause of Death

93. Date of Death

94. Place of Death

95. Age

96. Sex

97. Race

98. Occupation

99. Cause of Death

100. Date of Death

101. Place of Death

102. Age

103. Sex

104. Race

105. Occupation

106. Cause of Death

107. Date of Death

108. Place of Death

109. Age

110. Sex

111. Race

112. Occupation

113. Cause of Death

114. Date of Death

115. Place of Death

116. Age

117. Sex

118. Race

119. Occupation

120. Cause of Death

121. Date of Death

122. Place of Death

123. Age

124. Sex

125. Race

126. Occupation

127. Cause of Death

128. Date of Death

129. Place of Death

130. Age

131. Sex

132. Race

133. Occupation

134. Cause of Death

135. Date of Death

136. Place of Death

137. Age

138. Sex

139. Race

140. Occupation

141. Cause of Death

142. Date of Death

143. Place of Death

144. Age

145. Sex

146. Race

147. Occupation

148. Cause of Death

149. Date of Death

150. Place of Death

151. Age

152. Sex

153. Race

154. Occupation

155. Cause of Death

156. Date of Death

157. Place of Death

158. Age

159. Sex

160. Race

161. Occupation

162. Cause of Death

163. Date of Death

164. Place of Death

165. Age

166. Sex

167. Race

168. Occupation

169. Cause of Death

170. Date of Death

171. Place of Death

172. Age

173. Sex

174. Race

175. Occupation

176. Cause of Death

177. Date of Death

178. Place of Death

179. Age

180. Sex

181. Race

182. Occupation

183. Cause of Death

184. Date of Death

185. Place of Death

186. Age

187. Sex

188. Race

189. Occupation

190. Cause of Death

191. Date of Death

192. Place of Death

193. Age

194. Sex

195. Race

196. Occupation

197. Cause of Death

198. Date of Death

199. Place of Death

200. Age

201. Sex

202. Race

203. Occupation

204. Cause of Death

205. Date of Death

206. Place of Death

207. Age

208. Sex

209. Race

210. Occupation

211. Cause of Death

212. Date of Death

213. Place of Death

214. Age

215. Sex

216. Race

217. Occupation

218. Cause of Death

219. Date of Death

220. Place of Death

221. Age

222. Sex

223. Race

224. Occupation

225. Cause of Death

226. Date of Death

227. Place of Death

228. Age

229. Sex

230. Race

231. Occupation

232. Cause of Death

233. Date of Death

234. Place of Death

235. Age

236. Sex

237. Race

238. Occupation

239. Cause of Death

240. Date of Death

241. Place of Death

242. Age

243. Sex

244. Race

245. Occupation

246. Cause of Death

247. Date of Death

248. Place of Death

249. Age

250. Sex

251. Race

252. Occupation

253. Cause of Death

254. Date of Death

255. Place of Death

256. Age

257. Sex

258. Race

259. Occupation

260. Cause of Death

261. Date of Death

262. Place of Death

263. Age

264. Sex

265. Race

266. Occupation

267. Cause of Death

268. Date of Death

269. Place of Death

270. Age

271. Sex

272. Race

273. Occupation

274. Cause of Death

275. Date of Death

276. Place of Death

277. Age

278. Sex

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02431

2432 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>AA</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>AA</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Annapolis</u>		TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		<u>16 Bausum Drive</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>Florence B. Bausum</u>		<u>3-22-1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Nov 23^d 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Housewife</u>		<u>None</u>	<u>Winchester Va</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Harry I Hilborn</u>		<u>Mary Burk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<u>Fred W. Bausum</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis-Cardio-</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Vascular Disease</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/56</u> , 19 <u>56</u> , to <u>3/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>56</u> , and that death occurred at <u>12:07 A.M.</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Albert H. Cuckern</u>		<u>3/27/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
<u>Burial</u>		<u>3-27-56</u>	
DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>3-27-56</u>		<u>Hillcrest</u>	
LOCATION (City, town, or county)		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>Annapolis Md</u>		<u>John W. Taylor Sons</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>John W. Taylor Sons</u>		<u>Annapolis Md</u>	
DATE <u>3-27-1956</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02432

2433

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>10 Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena Rd</u>			
c. LENGTH OF STAY IN 1b <u>DOA?</u>				d. STREET ADDRESS <u>Rt. #1 - Box #23</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>99 Anne Arundel General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Durning</u> Last <u>Boan</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 August 1906</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u>49</u> Days <u>49</u> Hours <u>49</u> Min. <u>49</u>		IF UNDER 24 HRS. Months <u>49</u> Days <u>49</u> Hours <u>49</u> Min. <u>49</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laymaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merrit-Chapman Scott</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sam Boan</u>				14. MOTHER'S MAIDEN NAME <u>Anne Durning</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>050-07-6007</u>		17. INFORMANT <u>Mrs. George Boan</u>		Address <u>Rt. #1 - Box 23 Pasadena Rd, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> DUE TO (c) <u>UNKNOWN</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 HRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/23</u> , 19 <u>56</u> , to <u>3/23</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3/23/56</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>3/24/56</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>				ADDRESS <u>Glenn Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u> <u>27 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. Brunch</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. PLACE OF DEATH City or Town		2. SEX Male Female		3. AGE Years Months Days	
4. OCCUPATION		5. CAUSE OF DEATH		6. MANNER OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF BURIAL	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CLERK		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF SHERIFF		17. SIGNATURE OF TOWNSHIP CLERK		18. SIGNATURE OF COUNTY CLERK	
19. SIGNATURE OF STATE CLERK		20. SIGNATURE OF FEDERAL CLERK		21. SIGNATURE OF POSTAL CLERK	
22. SIGNATURE OF TELEGRAPH CLERK		23. SIGNATURE OF RAILROAD CLERK		24. SIGNATURE OF AIRLINE CLERK	
25. SIGNATURE OF MARINE CLERK		26. SIGNATURE OF NAVY CLERK		27. SIGNATURE OF ARMY CLERK	
28. SIGNATURE OF AIR FORCE CLERK		29. SIGNATURE OF SPACE CLERK		30. SIGNATURE OF OTHER CLERK	

BUREAU V. S.

MAR 27 1956

RECEIVED

2466

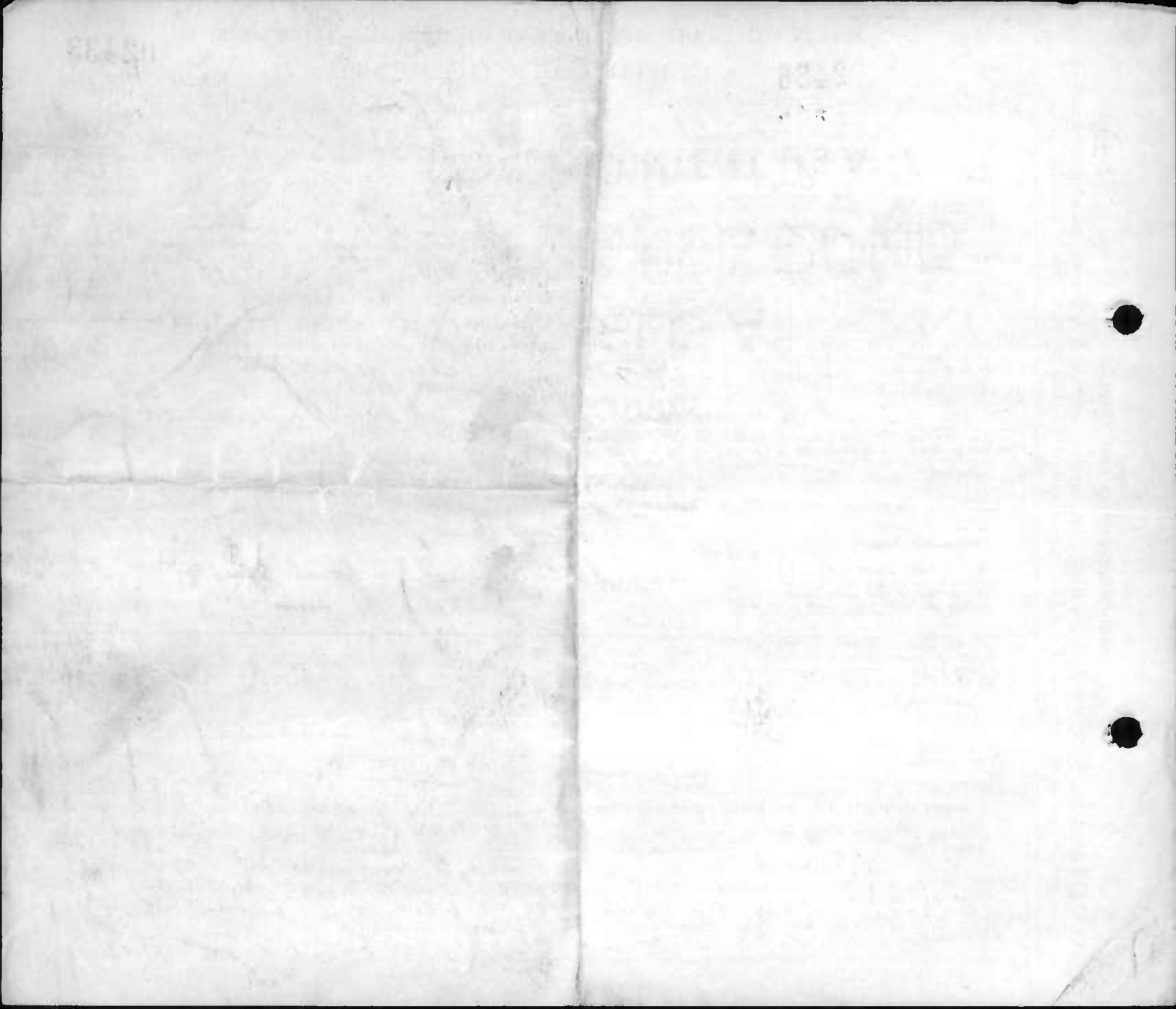
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Balts. City</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Pasadena</i>		LENGTH OF STAY (in this place) <i>9 mos</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		<i>3401-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>home P.O. box 53 Mill Rd.</i>				STREET ADDRESS (If rural give location) <i>1040 W. Baltimore St</i>			
3. NAME OF DECEASED: (First) <i>SADIE</i> (Middle) <i>ELIZABETH</i> (Last) <i>BRAUN</i>				4. DATE OF DEATH: (Month) <i>March</i> (Day) <i>13</i> (Year) <i>1956</i>			
5. SEX: <i>F</i>		6. COLOR OR RACE: <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>10 January 1896</i>	
				9. AGE last birthday: <i>60</i> yrs.		10. IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>at home</i>		11. BIRTHPLACE (State or foreign country): <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>yes USA</i>	
13. FATHER'S NAME: <i>Fred Hungog (dec.)</i>				14. MOTHER'S MAIDEN NAME: <i>Henrietta Freeline (dec.)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY No.: <i></i>		17. INFORMANT & ADDRESS: <i>Edward Braun (husband) Same address.</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <i>442X Congestive Heart Failure</i>						<i>11 days</i>	
Antecedent causes (s) (b) <i>Advanced Cardis-Vascular Renal Disease</i>						<i>5 yrs</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <i>none</i>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>none</i>							
19a. DATE OF OPERATION: <i>none</i>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify) <i>none</i>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i></i>		(CITY OR TOWN) <i></i>		(COUNTY) <i></i> (STATE) <i></i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i></i>		INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/>		HOW DID INJURY OCCUR? <i></i>			
22. I hereby certify that I attended the deceased from <i>July</i> , 19 <i>55</i> , to <i>March 13</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>March 8</i> , 19 <i>56</i> , and that death occurred at <i>4:30 AM</i> from the causes and on the date stated above.							
SIGNATURE <i>H.F. Manuzak M.D.</i>		(Degree or title)		ADDRESS <i>Eastway & Edgerly Rd, Glen Burnie, Md</i>		DATE SIGNED <i>13 March 1956</i>	
23. BURIAL, CREMATION, REMOVAL. (Specify) <i>Burial</i>		DATE THEREOF <i>3/16/56</i>		NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cem.</i>		LOCATION (City, town, or county) (State) <i>Pitcher Hwy Ritchie Hgwy</i>	
DATE REC'D BY LOCAL REGISTRAR <i>3-13-56</i>		REGISTRAR'S SIGNATURE <i>H.F. Manuzak</i>		24. FUNERAL DIRECTOR <i>John J. Cowan & Son</i>		ADDRESS <i>St. Hollins</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 18&21 Film G194 3-16-56

02434

2467

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville State Hospital</u> 5yrs. 4mos.				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Newark</u> 23X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Bertie</u> (First) <u>Briddell</u> (Middle) (Last)				4. DATE OF DEATH 3 7 19 56 (Month) (Day) (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12/25/81</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Ezechiel Purnell</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
260X IMMEDIATE CAUSE (A) <u>Myocardial Degeneration</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>905-7</u> (B) <u>Fracture of hip</u> <u>Diabetes</u> (C)						<u>1/27/56</u> <u>Many years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis with Cerebral Arteriosclerosis</u>						<u>Known since adm. 10/27/50</u>	
19a. DATE OF OPERATION - -		19b. MAJOR FINDINGS OF OPERATION - - - - -		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Crownsville State Hosp.</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>-Crownsville-</u> <u>A.A.</u> <u>Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Jan. 26 1956 M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Due to fall</u>			
22. I hereby certify that I attended the deceased from <u>10/27</u> , 19 <u>50</u> , to <u>3/7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/7</u> , 19 <u>56</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		(L. Benedict) M.D.		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/7/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>3/12/56</u>		DATE THEREOF <u>3/12/56</u>		NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Newark Md</u>	
24. REC'D BY REGISTRAR DATE <u>12 1956</u>		REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>S. J. Stewart</u>		ADDRESS <u>Salisbury, Md.</u>	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Date of Death	
3. Age		4. Sex	
5. Race		6. Marital Status	
7. Occupation		8. Cause of Death	
9. Place of Death		10. Signature of Physician	
11. Signature of Registrar		12. Date of Registration	

INSTRUCTIONS

1. This certificate is to be filled out by the physician attending the deceased or by the coroner if the death is sudden and unexpected.

2. The cause of death should be stated in full, including the immediate cause, the underlying cause, and any other conditions which may have contributed to the death.

3. The place of death should be stated as either at home, in a hospital, or in a nursing home.

4. The signature of the physician or coroner must be written in ink.

5. The signature of the registrar must be written in ink.

6. The date of registration must be written in ink.

7. This certificate is to be filed in the office of the Registrar of Deaths.

8. A copy of this certificate will be sent to the family of the deceased.

9. A copy of this certificate will be sent to the local health department.

10. A copy of this certificate will be sent to the State Department of Health.

RECEIVED

BUREAU V. 2

MAR 12 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2434

CERTIFICATE OF DEATH

Reg. Dist. No. 2

02435

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS, MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>63 H.A. GENERAL Hosp</u>				d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BABY</u> First <u>GIRL</u> Middle <u>BURTIS</u> Last				4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/27/56</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>DANIEL C. BURTIS</u>				14. MOTHER'S MAIDEN NAME <u>HMETIA E. GALLAWAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>DANIEL C. BURTIS</u> Address <u>ANNAPOLIS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Pulmonary atelectasis</u> DUE TO (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 day</u> DUE TO (c) <u>1 day</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 Mar</u> , 19 <u>56</u> , to <u>28 Mar</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>28 Mar</u> , 19 <u>56</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. W. WALKER</u> M.D.				ADDRESS (Street, city or town, state) <u>ANNAPOLIS MD</u> DATE SIGNED <u>29 Mar 56</u>			
PHYSICIAN'S NAME (Type) <u>S. W. WALKER</u>				ADDRESS <u>ANNAPOLIS MD</u> DATE <u>3/29/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLVD</u>		22d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. 1919 + Sons</u> ADDRESS <u>ANNAPOLIS, MD</u>				24a. REC'D BY REGISTRAR <u>DATE 3/30/1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3181

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

APR 2 1956

RECEIVED

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is partially filled out with handwritten text.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02436

CERTIFICATE OF DEATH

Reg. Dist. No. 12

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dorsey</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dorsey</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Race Road</u>				STREET ADDRESS (If rural give location) <u>Race Road</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Herbert</u> <u>Butler</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> <u>14</u> <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 10 - 1895</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Katie Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, eq, or unk.) <u>yes</u>		16. SOCIAL SECURITY NO. <u>I</u>		17. INFORMANT & ADDRESS <u>Clarence Hamilton RFD #1 Box 310 Hanover, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arterio Sclerosis 6 yrs</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec, 1920, to Feb 19 56, that I last saw the deceased alive on Feb 14 1956, and that death occurred at 4:20 PM, from the causes and on the date stated above.							
SIGNATURE <u>Robert Brownbaugh</u> M.D. 8609 Main St Elkhridge 2nd				DATE SIGNED <u>3/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/19/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 19 1956</u>		REGISTRAR'S SIGNATURE <u>Clara Fiedler</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles R. Law 802-04 Madison Ave.</u>			

CERTIFICATE OF DEATH

DATE OF DEATH

DEATH RECORDING NUMBER

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

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TIME OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

BUREAU V. S.

1936

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2469 CERTIFICATE OF DEATH

02437

Item 7, Film G194 3-23-56 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>ANNE ARUNDEL</i> MARYLAND				STATE _____ COUNTY <i>AA Co Md</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <i>PATAPSCO PARK</i>				<i>Patapsco Park</i>		<i>x</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>218 BERLIN AVE</i>				STREET ADDRESS (If rural give location) <i>218 Berlin Ave</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>EDWARD BYRD</i>				<i>March 15 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M</i>	<i>C</i>	<i>Widowed</i>		<i>77</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Ad. Framing</i>				<i>St. C.</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>James Byrd</i>				<i>Mary Smith</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>				<i>Cora Hill 218 Berlin Ave</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <i>Congestive Heart Failure</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Thrombosis</i>						<i>4 days</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <i>Arteriosclerotic Heart Disease</i>						<i>24 hrs.</i>	
STATING UNDERLYING CAUSE LAST.						<i>2 yrs +</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct 10, 1955</i> , to <i>Mar 15, 1956</i> , that I last saw the deceased alive on <i>March 15, 1956</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.							
SIGNATURE <i>C. Milton Luthien</i> M.D.				ADDRESS (Street, city, town, state) <i>1415 1st St N</i>		DATE SIGNED <i>3/15/56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>3/19/56</i>		<i>Int Calvary</i>		<i>AA Co Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>MAR 19 1956</i>		<i>Dr. Caldwell Woodruff</i>		<i>Sarah L Brown Son</i>		<i>10840 Montg omery Rd</i>	

BUREAU V. S.

MAR 20 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2470 CERTIFICATE OF DEATH

02438

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>9 mos. 11 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>		<u>20-40-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Zeke</u> (First) <u>Campbell</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>27</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Not given</u>	9. AGE last birthday <u>63?</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>		11. BIRTHPLACE (State or foreign country) <u>Unk.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unk.</u>	
13. FATHER'S NAME <u>Unk.</u>				14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Myocardial failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Since 2/4/56</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>0-2-6-8</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CNS Syphilis, left side hemiplegia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/16</u> , 19 <u>55</u> , to <u>3/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>55</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Hedgerd Heard Reinmann</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/29/56</u>		NAME OF CEMETERY OR CREMATORY <u>Crownsville State Hospital</u>		LOCATION (City, town, or county) (State) <u>Crownsville, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>3-29-56</u>		REGISTRAR'S SIGNATURE <u>K. M. Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stanley C. Burgess</u>		ADDRESS <u>Crownsville, Md.</u>	

	2007	2008	2009	2010
1. <i>Chrysomelidae</i>	10	10	10	10
2. <i>Curculionidae</i>	10	10	10	10
3. <i>Chrysomelidae</i>	10	10	10	10
4. <i>Chrysomelidae</i>	10	10	10	10
5. <i>Chrysomelidae</i>	10	10	10	10
6. <i>Chrysomelidae</i>	10	10	10	10
7. <i>Chrysomelidae</i>	10	10	10	10
8. <i>Chrysomelidae</i>	10	10	10	10
9. <i>Chrysomelidae</i>	10	10	10	10
10. <i>Chrysomelidae</i>	10	10	10	10
11. <i>Chrysomelidae</i>	10	10	10	10
12. <i>Chrysomelidae</i>	10	10	10	10
13. <i>Chrysomelidae</i>	10	10	10	10
14. <i>Chrysomelidae</i>	10	10	10	10
15. <i>Chrysomelidae</i>	10	10	10	10
16. <i>Chrysomelidae</i>	10	10	10	10
17. <i>Chrysomelidae</i>	10	10	10	10
18. <i>Chrysomelidae</i>	10	10	10	10
19. <i>Chrysomelidae</i>	10	10	10	10
20. <i>Chrysomelidae</i>	10	10	10	10
21. <i>Chrysomelidae</i>	10	10	10	10
22. <i>Chrysomelidae</i>	10	10	10	10
23. <i>Chrysomelidae</i>	10	10	10	10
24. <i>Chrysomelidae</i>	10	10	10	10
25. <i>Chrysomelidae</i>	10	10	10	10
26. <i>Chrysomelidae</i>	10	10	10	10
27. <i>Chrysomelidae</i>	10	10	10	10
28. <i>Chrysomelidae</i>	10	10	10	10
29. <i>Chrysomelidae</i>	10	10	10	10
30. <i>Chrysomelidae</i>	10	10	10	10
31. <i>Chrysomelidae</i>	10	10	10	10
32. <i>Chrysomelidae</i>	10	10	10	10
33. <i>Chrysomelidae</i>	10	10	10	10
34. <i>Chrysomelidae</i>	10	10	10	10
35. <i>Chrysomelidae</i>	10	10	10	10
36. <i>Chrysomelidae</i>	10	10	10	10
37. <i>Chrysomelidae</i>	10	10	10	10
38. <i>Chrysomelidae</i>	10	10	10	10
39. <i>Chrysomelidae</i>	10	10	10	10
40. <i>Chrysomelidae</i>	10	10	10	10
41. <i>Chrysomelidae</i>	10	10	10	10
42. <i>Chrysomelidae</i>	10	10	10	10
43. <i>Chrysomelidae</i>	10	10	10	10
44. <i>Chrysomelidae</i>	10	10	10	10
45. <i>Chrysomelidae</i>	10	10	10	10
46. <i>Chrysomelidae</i>	10	10	10	10
47. <i>Chrysomelidae</i>	10	10	10	10
48. <i>Chrysomelidae</i>	10	10	10	10
49. <i>Chrysomelidae</i>	10	10	10	10
50. <i>Chrysomelidae</i>	10	10	10	10
51. <i>Chrysomelidae</i>	10	10	10	10
52. <i>Chrysomelidae</i>	10	10	10	10
53. <i>Chrysomelidae</i>	10	10	10	10
54. <i>Chrysomelidae</i>	10	10	10	10
55. <i>Chrysomelidae</i>	10	10	10	10
56. <i>Chrysomelidae</i>	10	10	10	10
57. <i>Chrysomelidae</i>	10	10	10	10
58. <i>Chrysomelidae</i>	10	10	10	10
59. <i>Chrysomelidae</i>	10	10	10	10
60. <i>Chrysomelidae</i>	10	10	10	10
61. <i>Chrysomelidae</i>	10	10	10	10
62. <i>Chrysomelidae</i>	10	10	10	10
63. <i>Chrysomelidae</i>	10	10	10	10
64. <i>Chrysomelidae</i>	10	10	10	10
65. <i>Chrysomelidae</i>	10	10	10	10
66. <i>Chrysomelidae</i>	10	10	10	10
67. <i>Chrysomelidae</i>	10	10	10	10
68. <i>Chrysomelidae</i>	10	10	10	10
69. <i>Chrysomelidae</i>	10	10	10	10
70. <i>Chrysomelidae</i>	10	10		

11. REFERENCES

PIPERAL V

APR 5 1955

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10/11/1991

THE UNIVERSITY OF CHICAGO

BUREAU V. S.

APR 5 1955

17

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02439

2471 CERTIFICATE OF DEATH
Items 8, 9, Film G196 - 4/23/56

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN Ft George G Meade		1 Year		TOWN Fort George G. Meade		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
150 U.S. Army Hospital				Quarters 2336-C			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Robert (Middle) D. (Last) Carlisle				(Month) March (Day) 30 (Year) 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Cau	Married	21 January 1930	25 26 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Soldier			U. S. Army		Petersburg, Virginia		U. S. A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Robert Arnold Carlisle				unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
Yes - Present						Qtrs 2336-C Anne Carlisle, (Wife) Ft Geo G Meade, Md	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Immediately	
825X IMMEDIATE CAUSE (A) Severe Cronial Trauma							
ANTECEDENT CAUSE(S) DUE TO						Immediately	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
				Fort George G. Meade, Maryland A. Arundel MD			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
March 30, 1956 6:00 P.M.				Automobile accident			
22. I hereby certify that I attended the deceased from 30 March, 1956, to 30 March, 1956, that I last saw the deceased alive on 30 March 1956, and that death occurred at 1215 HRS. M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Richard M. M. [Signature]				ADDRESS (Street, city, town, state) DATE SIGNED 31 March '56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial				Blandford Cemetery		Petersburg, Virginia	
24. REC'D BY REGISTRAR				25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
31 March 56				William Cook, Inc, Baltimore, Md			

BUREAU V. S.

APR 3 1956

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02440

2472 **CERTIFICATE OF DEATH**

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		LENGTH OF STAY (in this place) <u>5 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sands Nursing Home</u>		STREET ADDRESS <u>Harold Harbor Rd.</u>					
3. NAME OF DECEASED (First) <u>AMOS</u> (Middle) <u>C</u> (Last) <u>CARR</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>8</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 1, 1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Amos Carr</u>				14. MOTHER'S MAIDEN NAME <u>Mary V. Lancaster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs Alice V. Carr</u> <u>Wife</u> <u>same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
144X IMMEDIATE CAUSE (A) <u>Adeno Carcinoma of Mouth</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 55</u> , 19 <u>55</u> , to <u>Mar 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 6</u> , 19 <u>56</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Phemist</u>				ADDRESS (Street, city, town, state) <u>Baltimore</u>		DATE SIGNED <u>3-8-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 10, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial Cemet.</u>		LOCATION (City, town, or county) (State) <u>Millersville, Maryland</u>	
24. REC'D BY REGISTRAR <u>3-10-56 3:20 PM JH</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>WOPPING FUNERAL HOME</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	

NOTIFICATION

1. Name of deceased: [Name]
 2. Date of death: [Date]
 3. Place of death: [Place]
 4. Cause of death: [Cause]
 5. Manner of death: [Manner]
 6. Age at death: [Age]
 7. Sex: [Sex]
 8. Race: [Race]
 9. Marital status: [Status]
 10. Occupation: [Occupation]
 11. Education: [Education]
 12. Social Security Number: [Number]
 13. Date of birth: [Date]
 14. Place of birth: [Place]
 15. Date of arrival in country: [Date]
 16. Date of departure from country: [Date]
 17. Date of return to country: [Date]
 18. Date of death: [Date]
 19. Date of burial: [Date]
 20. Date of cremation: [Date]
 21. Date of interment: [Date]
 22. Date of exhumation: [Date]
 23. Date of reinterment: [Date]
 24. Date of removal of remains: [Date]
 25. Date of return of remains: [Date]
 26. Date of disposal of remains: [Date]
 27. Date of disposal of remains: [Date]
 28. Date of disposal of remains: [Date]
 29. Date of disposal of remains: [Date]
 30. Date of disposal of remains: [Date]

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. MARRIAGE

6. OCCUPATION

7. EDUCATION

8. SOCIAL SECURITY NUMBER

9. DATE OF BIRTH

10. PLACE OF BIRTH

11. DATE OF ARRIVAL IN COUNTRY

12. DATE OF DEPARTURE FROM COUNTRY

13. DATE OF RETURN TO COUNTRY

14. DATE OF DEATH

15. DATE OF BURIAL

16. DATE OF CREMATION

17. DATE OF INTERMENT

18. DATE OF EXHUMATION

19. DATE OF REINTERMENT

20. DATE OF REMOVAL OF REMAINS

21. DATE OF RETURN OF REMAINS

22. DATE OF DISPOSAL OF REMAINS

23. DATE OF DISPOSAL OF REMAINS

24. DATE OF DISPOSAL OF REMAINS

25. DATE OF DISPOSAL OF REMAINS

26. DATE OF DISPOSAL OF REMAINS

27. DATE OF DISPOSAL OF REMAINS

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48. DATE OF DISPOSAL OF REMAINS

49. DATE OF DISPOSAL OF REMAINS

50. DATE OF DISPOSAL OF REMAINS

BUREAU V. S.

MAR 27 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02441

2473

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 12, Film G194 3-23-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel Co.</u>		STATE <u>Md.</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>GREEN HAVEN</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)		ADDRESS <u>5th ST and OUTING AVE.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>LENA</u>		(Middle)		(Last) <u>CARSON</u>		<u>3/16</u> 19 <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>MAY 3/1889</u>	9. AGE last birthday <u>66</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>	11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWORK</u>		<u>Home</u>		<u>GERMANY</u>		<u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob Rihm</u>				14. MOTHER'S MAIDEN NAME <u>MATILDA -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Family - same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				<u>unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>				<u>unknown</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 10, 1955, to March 16, 1956, that I last saw the deceased alive on March 15, 1956, and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
SIGNATURE <u>R. M. McLaughlin</u>				DATE SIGNED <u>March 16, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>3/20/56</u>			
NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>				LOCATION (City, town, or county) (State) <u>Balto.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. DeAlly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James L. McCully</u>		ADDRESS <u>130 E. Fort Ave.</u>	
DATE <u>MAR 19 1956</u>							

BUREAU V. 8

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02442

2474 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Elvaton</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Elvaton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Waterford Road</u>				STREET ADDRESS (If rural give location) <u>Waterford Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Stanley W. Carter, Jr.</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH	9. AGE last birthday <u>1</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Annapolis, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stanley W. Carter, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia E. Pensing</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Stanley W. Carter, Sr. Elvaton MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
756.2 IMMEDIATE CAUSE (A) <u>Cirrhosis of liver</u>						1-year	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congenital obliteration of the bile ducts</u>						Since birth	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 18, 1954</u> , to <u>March 1, 1956</u> , that I last saw the deceased alive on <u>March 1, 1956</u> , and that death occurred at <u>4:12 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>R.M. McLaughlin</u>		DATE THEREOF <u>March 5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, MD.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>March 7, 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. McLaughlin</u>		DATE SIGNED <u>3/1/56</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02443

2435

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Q. Q.</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Q. Q.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Annapolis</i>				TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>U. S. General Hosp.</i>				STREET ADDRESS (If rural give location) <i>7 Thompson</i>			
3. NAME OF DECEASED (Type or Print) <i>Guy R. Clements</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>3 - 25 - 1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>3-5-1885</i>	9. AGE last birthday <i>71</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mathematics U.S. Naval Academy</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Parvettia Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Clifford Clements</i>				14. MOTHER'S MAIDEN NAME <i>Frances Gross</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk. <i>No</i>) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mildred M. Clements (2)</i>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1443X IMMEDIATE CAUSE (A) <i>Intracerebral hemorrhage</i>						INTERVAL BETWEEN ONSET AND DEATH <i>7 hrs.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive, arteriosclerotic cardiovascular disease</i>						<i>18 yrs.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/24</i>, 19<i>56</i>, to <i>3/25</i>, 19<i>56</i>, that I last saw the deceased alive on <i>3/25</i>, 19<i>56</i>, and that death occurred at <i>5:27</i> A.M. from the causes and on the date stated above. <i>3/25/56</i>							
SIGNATURE <i>John H. Hedzeman</i>		DATE THEREOF <i>3-27-56</i>		NAME OF CEMETERY OR CREMATORY <i>Hillcrest</i>		LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. REC'D BY REGISTRAR <i>J. J. D. D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS <i>90 Parkwood St. Annapolis, Md</i>	
DATE <i>3-27-1956</i>							

2436

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>914 Van Vuran Street</u>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>O</u> Last <u>COLBURN</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>14</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9, 1883</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Milton Colburn</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Margaret A. Hambruch-Daughter-</u>		Address <u>West Street Annapolis, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ANEMIA and DEBILITY</u> DUE TO (c) <u>BLEEDING PEPTIC ULCER</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS</u> <u>unknown</u> <u>4 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/10</u> , 19 <u>56</u> , to <u>3/14/56</u> , 19____, that I last saw the deceased alive on <u>3/14/56</u> , 19____, and that death occurred at <u>2:30A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Edward S. Beck MD</u> <u>41 Southgate Ave. Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>3-16-56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2388

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1956		BALTIMORE, MD	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPouse		DATE OF BIRTH		PLACE OF BIRTH	
MARRIED		JAN 10 1940		BALTIMORE, MD		MARY H. HARRIS		JAN 15 1915		BALTIMORE, MD	
EDUCATION		SCHOOLING		OCCUPATION		HISTORY OF ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
HIGH SCHOOL		12		LABORER		COLD AND FLU		HEART DISEASE		NATURAL	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		DATE OF BURIAL		NAME OF FUNERAL HOME		NAME OF MINISTER	
NONE		JAN 10 1956		JAN 15 1956		JAN 16 1956		JOHN J. HARRIS		JOHN J. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF FUNERAL HOME		SIGNATURE OF MINISTER	
JAMES H. HARRIS		MARY H. HARRIS		JOHN J. HARRIS		JOHN J. HARRIS		JOHN J. HARRIS		JOHN J. HARRIS	

BUREAU V. 1

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2437
CERTIFICATE OF DEATH

02445

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1200 West Street</u>		e. STREET ADDRESS <u>1200 West Street</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>DAVID</u> Last <u>CORDLE JR</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>18</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1906</u>
9. AGE (In years lost birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USNA Power Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES DAVID CORDLE SR</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE HOFFMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-05-0917</u>	
17. INFORMANT <u>Mrs Catherine Rogers Cordle- Wife- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Generalized</u> DUE TO <u>Generalized</u> (c) <u>Peptic (duodenal) Ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Peptic (duodenal) Ulcer</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-17-</u> 19 <u>56</u> , to <u>3-18-</u> 19 <u>56</u> , that I last saw the deceased alive on <u>3-18-</u> 19 <u>56</u> , and that death occurred at <u>6:45</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		ADDRESS (Street, city or town, state) <u>Prince George Street, Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James R. Martin MD</u>		DATE SIGNED <u>3-19-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 21, 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Haven, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		24a. REC'D BY REGISTRAR DATE <u>3-20-56</u>	
ADDRESS <u>ANNAPOLIS, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>J. Connel</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOWED		DIVORCED		REMARIED		OTHER		REMARKS	
OCCUPATION		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		ARMED SERVICES		REMARKS	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF CORONER		SIGNATURE OF JURY		REMARKS	

BUREAU V. S.

MAR 21 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

2438

CERTIFICATE OF DEATH

02446

Reg. Dist. No. 21

Items 7, 14, Film G195 1-12-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>A. A.</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>A. A.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Anne Arundel Gen'l Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>George</i> (First) <i>Crowner</i> (Middle) <i>Crowner</i> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <i>Mar 25</i> 19 <i>56</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Apr. 9, 1887</i>	9. AGE last birthday <i>69</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PILE DRIVING</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Thomas Crowner</i>				14. MOTHER'S MAIDEN NAME <i>Alice Turner</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>2-12-18-5646A</i>		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <i>Arteriosclerotic Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Chronic Pericarditis & Congestive Failure</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Failure</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Broncho-Pneumonia</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>March 7, 1956</i> , to <i>March 25, 1956</i> , that I last saw the deceased alive on <i>March 25, 1956</i> , and that death occurred at <i>11:00</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Reda R. Brown</i>				ADDRESS (Street, city, town, state) <i>110-Clayton Ave, Baltimore, Md</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3/29/56</i>		NAME OF CEMETERY OR CREMATORY <i>Crowner</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
24. REC'D BY REGISTRAR DATE <i>3/31/1956</i>		REGISTRAR'S SIGNATURE <i>J. J. ...</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard C. Hardisty</i>		ADDRESS	

2475 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Crownsville		4 mos. 11 days		TOWN 256 N. Exeter Street		3701-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) Baltimore City			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Hardinia (Middle) (Last) Comer				(Month) 3 (Day) 28 (Year) 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	Negro	Widow	Not given	87?	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unk.		Unk.		Unk.		Unk.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Not given				Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		Unk.		Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) Myocardial degeneration						6 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						6 days	
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
generalized arteriosclerosis							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. el work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/17, 19 55, to 3/28, 19 56, that I last saw the deceased alive on 3/28, 19 56, and that death occurred at 11:45 A.M. from the causes and on the date stated above.							
SIGNATURE		L. Benedict, M. D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
		M.D.		Crownsville, Md.		3/28/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		4/4/56		Mt Calvary Cem.		Brooklyn Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
APR 11 1956		R. M. Joyner		Elroy O. Wilson		Baltimore	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

3878

UNITED STATES DEPARTMENT OF HEALTH

NAME	DATE OF BIRTH	SEX	RACE	EDUCATION	RELIGION	DATE OF DEATH	PLACE OF DEATH	Cause of Death
John Doe	1925	M	W	High School	Methodist	April 10, 1956	Home	Heart Disease

DATE OF DEATH	PLACE OF DEATH	Cause of Death	DATE OF DEATH	PLACE OF DEATH	Cause of Death
April 10, 1956	Home	Heart Disease	April 10, 1956	Home	Heart Disease

DATE OF DEATH	PLACE OF DEATH	Cause of Death	DATE OF DEATH	PLACE OF DEATH	Cause of Death
April 10, 1956	Home	Heart Disease	April 10, 1956	Home	Heart Disease

DATE OF DEATH	PLACE OF DEATH	Cause of Death	DATE OF DEATH	PLACE OF DEATH	Cause of Death
April 10, 1956	Home	Heart Disease	April 10, 1956	Home	Heart Disease

DATE OF DEATH	PLACE OF DEATH	Cause of Death	DATE OF DEATH	PLACE OF DEATH	Cause of Death
April 10, 1956	Home	Heart Disease	April 10, 1956	Home	Heart Disease

DATE OF DEATH	PLACE OF DEATH	Cause of Death	DATE OF DEATH	PLACE OF DEATH	Cause of Death
April 10, 1956	Home	Heart Disease	April 10, 1956	Home	Heart Disease

BUREAU V. S.

APR 11 1956

RECEIVED

ENCLOSURE

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2476

CERTIFICATE OF DEATH

02447

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Centerville</u>		<u>17X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Post Office</u>			
3. NAME OF DECEASED (Type or Print) <u>Lum</u> (First) <u>Demby</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>March 28 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1852</u>	9. AGE last birthday <u>104</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>not given - U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cardiac Arrest</u>				INTERVAL BETWEEN ONSET AND DEATH <u>approx. 15"</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Generalized Arteriosclerosis</u>				Known to us since admission			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Senile Psychosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 9</u>, 19<u>56</u>, to <u>March 28</u>, 19<u>56</u>, that I last saw the deceased alive on <u>March 28</u>, 19<u>56</u>, and that death occurred at <u>11.10 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Hedward Heard Reinman</u> M.D. <u>Crownsville, Maryland</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal - Burial</u>		DATE THEREOF <u>4/3/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Corsica Neck Cemetery</u>		LOCATION (City, town, or county) (State) <u>R.F.D. Centerville, Md</u>	
24. REC'D BY REGISTRAR <u>APR 3 1956</u>		REGISTRAR'S SIGNATURE <u>H. M. Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. M. St. Lawrence</u>		ADDRESS <u>Cambridge, Md.</u>	

CERTIFICATE OF DEATH

Form 10-1-55

1. USUAL RESIDENCE OF DECEASED

MARYLAND

COUNTY OF

CITY OF

STREET

APARTMENT

ZIP CODE

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF HOSPITAL

NAME OF PHYSICIAN

NAME OF NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ASSISTANT PHYSICIAN

NAME OF PATHOLOGIST

NAME OF ANATOMIST

NAME OF RADIOLOGIST

NAME OF CLINICAL PATHOLOGIST

NAME OF LABORATORY

NAME OF CHEMIST

NAME OF MICROSCOPIC

NAME OF HISTOLOGIC

NAME OF CYTOLOGIC

NAME OF BACTERIOLOGIC

NAME OF VIROLOGIC

NAME OF IMMUNOLOGIC

NAME OF PARASITIC

NAME OF ENTOMOLOGIC

NAME OF ZOOLOGIC

NAME OF BOTANIC

NAME OF AGRICULTURAL

NAME OF FORESTRY

NAME OF FISHERY

NAME OF MINING

NAME OF METALLURGY

NAME OF CERAMIC

NAME OF TEXTILE

NAME OF LEATHER

NAME OF PAPER

NAME OF RUBBER

NAME OF GLASS

NAME OF CEMENT

NAME OF BRICK

NAME OF TILE

NAME OF MARBLE

NAME OF GRANITE

NAME OF SLATE

NAME OF LIME

NAME OF GYPSUM

NAME OF CEMENT

NAME OF BRICK

NAME OF TILE

NAME OF MARBLE

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NAME OF BRICK

NAME OF TILE

NAME OF MARBLE

NAME OF GRANITE

NAME OF SLATE

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02448

2439 CERTIFICATE OF DEATH

Reg. Dist. No. *21*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>A.A.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<i>10 TOWN Annapolis</i>				<i>TOWN Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>103 Severn Crest</i>				<i>R.F. D. #4</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Nellie Scott Dobson</i>				<i>3 22 56</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<i>Female</i>	<i>White</i>	<i>Widowed</i>	<i>Nov. 5, 1884</i>	<i>71</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Homemaker</i>				<i>Maryland</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Benjamin H. Scott</i>				<i>Ella Virginia Hiser</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<i>None</i>		<i>Mr. Scott Dobson R.F.D. #4 Annapolis, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
175x IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<i>Cancer of Bladder</i>						<i>about 7 months</i>	
ANTECEDENT CAUSE(S) DUE TO (B)							
<i>Cancer of Ovary</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<i>operated 3 yrs previously</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<i>April 1952</i>		<i>Cancer of Ovary right</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 15, 1955</i>, to <i>March 22, 1956</i>, that I last saw the deceased alive on <i>March 22, 1956</i>, and that death occurred at <i>2 A.M.</i> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>William P. Purnis</i>				<i>M.D. Annapolis Md</i>		<i>3/22/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>3/24/56</i>		<i>Woodlawn</i>		<i>Woodlawn, Md.</i>	
24. DEC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>March 23, 1956</i>		<i>Wm. J. French</i>		<i>Wm. J. Pinner</i>		<i>1704 Ave Balto 17, Md</i>	

CERTIFICATE OF DEATH

Form 1001-100

ATTEST: I hereby certify that the foregoing is a true and correct copy of the original as filed in the office of the Registrar of Deaths.

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO COffin

DATE OF ENTRY INTO GRAVE

DATE OF ENTRY INTO BURIAL

DATE OF ENTRY INTO INTERMENT

DATE OF ENTRY INTO CREMATION

DATE OF ENTRY INTO DISPOSITION

DATE OF ENTRY INTO FINAL REST

DATE OF ENTRY INTO PERMANENT HOME

DATE OF ENTRY INTO ETERNITY

DATE OF ENTRY INTO GLORY

DATE OF ENTRY INTO HEAVEN

DATE OF ENTRY INTO PARADISE

DATE OF ENTRY INTO ELYSIUM

DATE OF ENTRY INTO BLISS

DATE OF ENTRY INTO JOY

DATE OF ENTRY INTO PEACE

DATE OF ENTRY INTO HAPPINESS

DATE OF ENTRY INTO WELL-BEING

DATE OF ENTRY INTO CONTENTMENT

DATE OF ENTRY INTO SATISFACTION

DATE OF ENTRY INTO COMFORT

DATE OF ENTRY INTO EASE

DATE OF ENTRY INTO RELAXATION

DATE OF ENTRY INTO REST

DATE OF ENTRY INTO SLEEP

DATE OF ENTRY INTO DEATH

DATE OF ENTRY INTO THE GREAT UNKNOWN

DATE OF ENTRY INTO THE GREAT UNKNOWN

DATE OF ENTRY INTO THE GREAT UNKNOWN

DATE OF ENTRY INTO THE GREAT UNKNOWN

DATE OF ENTRY INTO THE GREAT UNKNOWN

DATE OF ENTRY INTO THE GREAT UNKNOWN

BUREAU V. S.

MAR 27 1956

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2477

CERTIFICATE OF DEATH

02449

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ANN ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY ANN ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENBURNIE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENBURNIE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AT HOME		d. STREET ADDRESS ROUTE #2 P.O. BOX # 382	
3. NAME OF DECEASED (Type or print) First MARY Middle ESTELLE Last DORSEY		4. DATE OF DEATH Month 3/20/1956 Day 19 Year 19	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1894
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME REUBEN MUSE		14. MOTHER'S MAIDEN NAME ELEANOR MUSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT GEORGE R. DORSEY-ET #2, BOX #382 GLENBURNIE, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes DUE TO Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 18, 1956 , to Mar 20, 1956 that I last saw the deceased alive on Mar 18, 1956 , and that death occurred at 12:30 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Woolridge M.D.		ADDRESS (Street, city or town, state) Rt Box 212 Ellicott City, Md. DATE SIGNED 3-22-56	
PHYSICIAN'S NAME (Type) THOMAS J. WOOLRIDGE, M.D.		WASHINGTON BLVD. DORSEY, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3/23/56	22c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem.	22d. LOCATION (City, town, or county) (State) BALTO MD.
23. FUNERAL DIRECTOR'S SIGNATURE Chas. H. Corbin		24a. REC'D BY REGISTRAR March 23, 1956	
ADDRESS 512 Convent Ave		24b. REGISTRAR'S SIGNATURE L. J. Sealy	

CERTIFICATE OF DEATH

2477

1956

DATE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

ICD-9 CODE

PLACE OF DEATH

DATE OF BIRTH

DATE OF DEATH

1956

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

ICD-9 CODE

0

1

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

DATE OF DEATH

STATE OF MARYLAND

DATE

1. I, the undersigned, being a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the person named above.

BUREAU V. S.

MAR 27 1956

RECEIVED

2440

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. General Hosp.</u>		d. STREET ADDRESS <u>24 Pleasant St.</u>	
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>EADES</u> Middle Last		4. DATE OF DEATH Month <u>3</u> - Day <u>2</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-1912</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u> IF UNDER 24 HRS. Hours <u>4</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Eades</u>		14. MOTHER'S MAIDEN NAME <u>Lemma Jennings</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-0883</u>	
17. INFORMANT <u>Mary Nell Eades</u>		Address <u>23</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BILATERAL BRONCHOPNEUMONIA WITH ATELECTASIS</u> 983X DUE TO <u>ASPIRATION OF PURULENT SECRETIONS</u> Conditions, if any, which gave rise to immediate cause (b) <u>EXTENSIVE LYE BURNS OF FACE & NECK</u> (c) <u>2 WEEKS</u> DUE TO <u>2 WEEKS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 WEEKS</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>WIFE THREW LYE SOLUTION ON HIM</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>2-18</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. S. FISHER</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. Fisher M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-6-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer's Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		ADDRESS <u>1108 Washington St. Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov. 5, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
CITY		COUNTY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
SIGNATURE OF WITNESS		DATE OF SIGNATURE	
PLACE OF SIGNATURE		CITY	
COUNTY		STATE	

RECEIVED
 MAR 6 1956
 BUREAU V. S.

2441

CERTIFICATE OF DEATH

02451

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood</u>		d. STREET ADDRESS <u>13 Dean St</u>	
3. NAME OF DECEASED (Type or print) <u>Alice J. Farra</u>		4. DATE OF DEATH <u>3 - 6 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 4 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Christfield Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Puley Byrd</u>		14. MOTHER'S MAIDEN NAME <u>Sally Corbin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Wm Y. McCreedy</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>421.4 Congestive Heart Failure</u> DUE TO (b) <u>Myo Endocarditis</u> DUE TO (c) <u>General Anasarca</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Several Months</u> <u>Several yrs</u> <u>Several Mths</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 24</u> , 19 <u>55</u> , to <u>March 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 5</u> , 19 <u>56</u> , and that death occurred at <u>1:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Oliver Parvis</u>		ADDRESS (Street, city or town, State) <u>Annapolis Md</u>	
PHYSICIAN'S NAME (Type) <u>J. OLIVER PARVIS</u>		DATE SIGNED <u>3/7/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-8-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>
22d. LOCATION (City, town, or county) <u>Annapolis</u>		(State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Golm M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 3-8-56</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. Tamm</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

02452

2442 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>21 Maryland Ave.</u>				STREET ADDRESS <u>21 Maryland Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Margaret Gordon Foot</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3-24-1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SPECIFY <u>Widow</u>	8. DATE OF BIRTH <u>Nov 19-1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Angers Ontario Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James S. Buchanan</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>George L Jones</u> (2)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
170X IMMEDIATE CAUSE (A) <u>CARCINOMA OF BREAST, METASTATIC</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/24</u> , 19 <u>56</u> , to <u>3/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>56</u> , and that death occurred at <u>3 A</u> .M., from the causes and on the date stated above.							
SIGNATURE <u>Edward A. Buckner</u> M.D.				ADDRESS (Street, city, town, state) <u>44 South East Lane, Annapolis</u>			
DATE SIGNED <u>3/27-56</u>				DATE SIGNED <u>3/27/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>3-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cem</u>		LOCATION (City, town, or county) (State) <u>Prince Geo Co Md</u>	
24. REC'D BY REGISTRAR <u>J. J. J. J.</u>		REGISTRAR'S SIGNATURE <u>J. J. J. J.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
DATE <u>3-27-56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A155 1-55 10M

CERTIFICATE OF DEATH

Reg. No. 100

1. FULL RESIDENCE OF DECEASED

2. PLACE OF DEATH
 3. DATE OF DEATH
 4. TIME OF DEATH
 5. PLACE OF BURIAL

6. NAME OF DECEASED
 7. SEX
 8. AGE
 9. RACE
 10. OCCUPATION

11. CAUSE OF DEATH
 12. MANNER OF DEATH

13. NAME OF PHYSICIAN
 14. SIGNATURE OF PHYSICIAN

15. NAME OF CORONER
 16. SIGNATURE OF CORONER

17. NAME OF MEDICAL EXAMINER
 18. SIGNATURE OF MEDICAL EXAMINER

19. NAME OF JURY
 20. SIGNATURE OF JURY

21. NAME OF JURY
 22. SIGNATURE OF JURY

23. NAME OF JURY
 24. SIGNATURE OF JURY

25. NAME OF JURY
 26. SIGNATURE OF JURY

27. NAME OF JURY
 28. SIGNATURE OF JURY

29. NAME OF JURY
 30. SIGNATURE OF JURY

31. NAME OF JURY
 32. SIGNATURE OF JURY

33. NAME OF JURY
 34. SIGNATURE OF JURY

35. NAME OF JURY
 36. SIGNATURE OF JURY

BUREAU V. S.

MAR 20 1956

RECEIVED

[Handwritten signature]

INSTRUCTIONS

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased. It is to be filled out in duplicate, one copy to be retained by the physician or coroner, and the other copy to be forwarded to the Bureau of Vital Statistics, Department of Health, Baltimore, Maryland. The certificate should be filled out as soon as possible after the death, and should be filled out in full, even if the death is due to natural causes. The certificate should be filled out in full, even if the death is due to natural causes. The certificate should be filled out in full, even if the death is due to natural causes.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02453

2478

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>A.A.</i>		MARYLAND		STATE <i>MD.</i>		COUNTY <i>A.A.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>		TOWN <i>Brooklyn</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>4139 Jexis Ave</i>				STREET ADDRESS (If rural give location) <i>4139 Jexis Ave.</i>			
3. NAME OF DECEASED (Type or Print) <i>Harry W. Fox</i>				4. DATE OF DEATH (Month) <i>3</i> (Day) <i>9</i> (Year) <i>1956</i>			
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>11-29-96</i>	9. AGE last birthday <i>59</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chem. Op.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mathieson</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Michael</i>				14. MOTHER'S MAIDEN NAME <i>Lena Bowman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <i>Yes</i>			16. SOCIAL SECURITY NO. <i>WA 1</i>		17. INFORMANT & ADDRESS <i>Family - Same</i>		
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
A. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<i>163X IMMEDIATE CAUSE (A) Lower of lung</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec 9, 1955</i> , to <i>March 9, 1956</i> , that I last saw the deceased alive on <i>March 9, 1956</i> , and that death occurred at <i>10:30 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Regina Elmer</i> M.D.				DATE SIGNED <i>3-10-56</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>				DATE THEREOF <i>3-12-56</i>		NAME OF CEMETERY OR CREMATORY <i>GLEN HAVEN</i>	
				LOCATION (City, town, or county) <i>BALTO</i>		(State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Ada M. Hutton</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>McElly</i> ADDRESS <i>FUNERAL HOMES</i>			
DATE <i>Mar. 12, 1956</i>							

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

REG. DIST. NO.

1. PLACE OF DEATH

2. NAME OF DECEASED
 3. SEX
 4. AGE
 5. DATE OF BIRTH
 6. PLACE OF BIRTH
 7. OCCUPATION
 8. MARITAL STATUS
 9. COLOR
 10. RELIGION
 11. EDUCATION
 12. SERVICE
 13. PREVIOUS ILLNESS
 14. CAUSE OF DEATH
 15. MANNER OF DEATH
 16. TIME OF DEATH
 17. PLACE OF DEATH
 18. SIGNATURE OF DECEASED
 19. SIGNATURE OF WITNESSES
 20. SIGNATURE OF PHYSICIAN
 21. SIGNATURE OF CORONER
 22. SIGNATURE OF REGISTRAR
 23. SIGNATURE OF CLERK
 24. SIGNATURE OF JURY
 25. SIGNATURE OF JUDGE
 26. SIGNATURE OF SHERIFF
 27. SIGNATURE OF CONSTABLE
 28. SIGNATURE OF TOWNSHIP CLERK
 29. SIGNATURE OF COUNTY CLERK
 30. SIGNATURE OF STATE CLERK

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

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BUREAU V. S.

MAR 12 1935

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2479 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02454

Reg. Dist. No. 22

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel-Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>New Cut Rd. nr. St. Rt. 602, Laurel Race Course</u>				d. STREET ADDRESS <u>610 Washington Blvd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Jesse</u> Last <u>Fuld</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1900</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isidore Fuld</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Stern</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>262-20-5883</u>		17. INFORMANT <u>Harry Cohen, 3807 Penhurst Ave</u>		Address <u>Balto Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (a) <u></u> (b) <u></u> (c) <u></u> DUE TO (a) <u></u> (b) <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u>		(County) <u></u>	(State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>David R. Martin</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/12/56</u>	
EXAMINER'S NAME (Type) <u>David R. Martin</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-15-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship Cem, Baltimore, Maryland</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		(State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David R. Martin</u>				24a. REC'D BY REGISTRAR <u>Clara Nesbitt</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Nesbitt</u>	
David R. Martin, 1902 Eutaw Place				DATE <u>3/15/56</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
 STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 15 1956

RECEIVED

NAME OF DECEASED (Print name in full)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE (In years and months)		DATE OF BIRTH	
PLACE OF BIRTH		DATE OF DEATH	
OCCUPATION		CAUSE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF WITNESS	
DATE OF EXAMINATION		TIME OF EXAMINATION	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
ADDRESS OF DECEASED		ADDRESS OF NEXT OF KIN	
CITY AND STATE		CITY AND STATE	
COUNTY		COUNTY	
ZIP CODE		ZIP CODE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02455

Reg. Dist. No. 22

1. PLACE OF DEATH o. COUNTY AA <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn,			c. LENGTH OF STAY IN 1b 18 yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 177, Old Annapolis Rd.				d. STREET ADDRESS Box 177, Old Annapolis Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle GENTRY Last GENTRY				4. DATE OF DEATH Month 3 Day 29 Year 1956			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1900	
				9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing Contractor				10b. KIND OF BUSINESS OR INDUSTRY Roofing Contractor		11. BIRTHPLACE (State or foreign country) Oklahoma	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas Gentry				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. 220-09-6443		17. INFORMANT Mrs Mary Gentry, same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) PAUL F. GUERIN				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 2, 1956		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James A. Kirkley				ADDRESS 421 Crain Highway, E. Glen Burnie, Md.		24a. REC'D BY REGISTRAR 4/4/56	
				24b. REGISTRAR'S SIGNATURE Charles Harsh			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
APR 4 1956
BUREAU V. S.

2481

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundle</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Anne Arundle</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Severn Md.</u>	<u>8 yrs</u>	TOWN <u>Severn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 2-Box 54</u>		STREET ADDRESS (If rural give location) <u>Route 2 Box 54</u>	

3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE (Month)	(Day)	(Year)
(Type or Print)	<u>Geneva</u>	<u>K</u>	<u>Green</u>	DEATH: <u>3</u>	<u>7</u>	<u>19 56</u>

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.
<u>Female</u>	<u>Col</u>	<u>Married</u>	<u>Dec 26, 1906</u>	<u>49</u> yrs.	Months	Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>Janitor</u>	<u>School</u>	<u>Gastonia N.C.</u>	<u>U.S.A.</u>

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
<u>James Boyce</u>	<u>Pearl Adams</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
		<u>Pearl Adams Same</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	<u>Carcinoma of the Urinary Bladder</u>	<u>2 years</u>
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.
--

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from 3-7, 1956, to 3-7, 1956 that I last saw the deceased alive on 3-7, 1956, and that death occurred at 9:10 PM, from the causes and on the date stated above.

SIGNATURE <u>Frederick A. H. [Signature]</u>	ADDRESS <u>M.D. 721 Medical Arts Bldg.</u>	DATE SIGNED <u>3-13-56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>3/14/56</u>	<u>Mt Calvary Cem</u>
		LOCATION (City, town, or county) (State)
		<u>Brooklyn Md</u>

DATE REC'D BY LOCAL REGISTRAR <u>3-14-56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Chas O. Wilson</u>	ADDRESS <u>1100 [Address]</u>
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GENERAL STATEMENT OF THE CONDITION OF THE AGRICULTURE OF THE UNITED STATES	
1. AGRICULTURE	2. LIVESTOCK
3. FISHERIES	4. MINING
5. MANUFACTURES	6. COMMERCE
7. TRANSPORTATION	8. EDUCATION
9. HEALTH	10. SOCIAL PROGRESS
11. FINANCE	12. CONCLUSION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02458

Items 8: 9: Film G196

5/11/56 dmr.

2482

CERTIFICATE OF DEATH

Reg. Dist. No.....

Item 7. Film G196 3-22-56 et

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>GREEN BURNIE</u> LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MAYOR</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> 3Y01-4 STREET ADDRESS (If rural give location) <u>1140 Stockton St.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Maria</u> (Middle) <u>Green</u> (Last) 4. DATE (Month) (Day) (Year) OF DEATH <u>March 12</u> 19 <u>56</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>C</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> 8. DATE OF BIRTH <u>18/10</u> 1898 9. AGE last birthday <u>58</u> <u>1891</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Richard Thomas-1647 W. North Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC</u> ANTECEDENT CAUSE(S) DUE TO <u>HEART DISEASE</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>HEART DISEASE</u> (C)						INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/6</u> 19 <u>56</u> , to <u>3/12</u> 19 <u>56</u> , that I last saw the deceased alive on <u>2/28</u> 19 <u>56</u> , and that death occurred at <u>4:15 P</u> M, from the causes and on the date stated above. SIGNATURE <u>Joseph Taler</u> 102 Balto. Hamp. ADDRESS (Street, city, town, state) <u>M.D. Blvd. N.E. Glen Burnie, Md.</u> DATE SIGNED <u>3/12/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/1/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. REC'D BY REGISTRAR <u>MAR 19 1956</u>		REGISTRAR'S SIGNATURE <u>L.G. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Jackson Fun. Home, Inc.</u>		ADDRESS <u>916 Penna. Ave. Balto., Md.</u>	

15458

DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

Reg. No. 15458

1. DATE WHEN DEATH OCCURRED

2. TIME

3. PLACE

4. CAUSE OF DEATH

5. MANNER OF DEATH

6. SEX

7. AGE

8. OCCUPATION

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX

12. CAUSE OF DEATH

13. MANNER OF DEATH

14. SEX

15. AGE

16. OCCUPATION

17. PLACE OF BIRTH

18. DATE OF BIRTH

19. SEX

20. CAUSE OF DEATH

21. MANNER OF DEATH

22. SEX

23. AGE

24. OCCUPATION

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. SEX

28. CAUSE OF DEATH

29. MANNER OF DEATH

30. SEX

31. AGE

32. OCCUPATION

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. SEX

36. CAUSE OF DEATH

37. MANNER OF DEATH

38. SEX

39. AGE

40. OCCUPATION

41. PLACE OF BIRTH

42. DATE OF BIRTH

43. SEX

44. CAUSE OF DEATH

45. MANNER OF DEATH

46. SEX

47. AGE

48. OCCUPATION

49. PLACE OF BIRTH

50. DATE OF BIRTH

51. SEX

52. CAUSE OF DEATH

53. MANNER OF DEATH

54. SEX

55. AGE

56. OCCUPATION

57. PLACE OF BIRTH

58. DATE OF BIRTH

59. SEX

60. CAUSE OF DEATH

61. MANNER OF DEATH

62. SEX

63. AGE

64. OCCUPATION

BUREAU V. S.

MAR 20 1956

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02459

2443

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 Fleet Street</u>		d. STREET ADDRESS <u>16 Fleet Street</u>	
3. NAME OF DECEASED (Type or print) <u>Blanche</u> First <u>Gross</u> Middle <u>Gross</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-7-1883</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Murray</u>		14. MOTHER'S MAIDEN NAME <u>Malinda Murray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Moses Gross</u>		Address <u>Rt 3, Annapolis, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the</u> <u>153X</u> DUE TO <u>Large Intestines</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>August 1955</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/15/55</u> to <u>3/15/56</u> , that I last saw the deceased alive on <u>3/15/56</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		ADDRESS (Street, city or town, state) <u>110-Clay St Annapolis, Md</u>	
PHYSICIAN'S NAME (Type) <u>R. L. Richardson M.D.</u>		DATE SIGNED <u>3/17/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		ADDRESS <u>108 Wash. St. Annapolis, Md</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Lench</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES J. JONES		45		M		W		1911		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
MAY 10 1956		10:00 AM		HOME		NEW YORK		NEW YORK		NEW YORK		MAY 10 1956		10:00 AM		HOME	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL		CATHOLIC		MARRIED		HEART DISEASE		NATURAL		FARMER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS	
JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES	

RECEIVED
MAR 10 1956
BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02460

2483

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Gambrills</u>		<u>4 Years</u>		TOWN <u>Gambrills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Residence</u>				STREET ADDRESS (If rural give location) <u>Gambrills, Md.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>REINHOLD (NMN) HABERLAND</u>				<u>March 25, 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>March 12, 1889</u>	<u>67</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Bricklayer</u>		<u>Construction</u>		<u>Germany</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Gustave Haberland</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmenia Jorden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u> (If Yes, give war or dates of service)		<u>110-07-9160</u>		<u>Mrs. Anna M. Haberland, Gambrills,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
241X IMMEDIATE CAUSE (A) <u>Emphysema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 Years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Asthma</u>						<u>10 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Bronchiectasis</u>						<u>5 Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 23, 1956</u> , to <u>Mar 25, 1956</u> , that I last saw the deceased alive on <u>Mar 23, 1956</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward J. Bennett</u>		M.D. <u>Gambrills Md</u>		DATE SIGNED <u>3-25-56</u>			
23. MANNER OF REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>March 28/56</u>		<u>Cedar Hill Crematory</u>		<u>Suitland, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3-29-56</u>		<u>[Signature]</u>		<u>W. W. CHAMBERS CO., Riverdale, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

5133

1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. PLACE OF BIRTH

9. DATE OF BIRTH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. PLACE OF INTERMENT

15. DATE OF INTERMENT

16. NAME OF FUNERAL HOME

17. NAME OF MINISTER

18. NAME OF CHURCH

19. NAME OF CEMETERY

20. NAME OF CITY

21. NAME OF STATE

22. NAME OF COUNTY

23. NAME OF DISTRICT

24. NAME OF WARD

25. NAME OF BLOCK

26. NAME OF LOT

27. NAME OF GRAVE

28. NAME OF MONUMENT

29. NAME OF INSCRIPTION

30. NAME OF DESIGNER

31. NAME OF CARVER

32. NAME OF SETTER

33. NAME OF FINISHER

34. NAME OF PAINTER

35. NAME OF POLISHER

36. NAME OF SHIPPER

37. NAME OF INSURER

38. NAME OF AGENT

39. NAME OF BROKER

40. NAME OF DEALER

41. NAME OF MERCHANT

42. NAME OF MANUFACTURER

43. NAME OF DISTRIBUTOR

44. NAME OF RETAILER

45. NAME OF WHOLESALE

46. NAME OF EXPORTER

47. NAME OF IMPORTER

BUREAU V. 2

APR 5 1912

RECEIVED

1. NAME OF DECEASED

2. NAME OF CITY

3. NAME OF STATE

4. NAME OF COUNTY

5. NAME OF DISTRICT

6. NAME OF WARD

7. NAME OF BLOCK

8. NAME OF LOT

9. NAME OF GRAVE

10. NAME OF MONUMENT

11. NAME OF INSCRIPTION

12. NAME OF DESIGNER

13. NAME OF CARVER

14. NAME OF SETTER

15. NAME OF FINISHER

16. NAME OF PAINTER

17. NAME OF POLISHER

18. NAME OF SHIPPER

19. NAME OF INSURER

20. NAME OF AGENT

21. NAME OF BROKER

22. NAME OF DEALER

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25. NAME OF DISTRIBUTOR

26. NAME OF RETAILER

27. NAME OF WHOLESALE

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37. NAME OF WHOLESALE

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43. NAME OF MERCHANT

44. NAME OF MANUFACTURER

45. NAME OF DISTRIBUTOR

46. NAME OF RETAILER

47. NAME OF WHOLESALE

48. NAME OF EXPORTER

49. NAME OF IMPORTER

50. NAME OF AGENT

51. NAME OF BROKER

52. NAME OF DEALER

53. NAME OF MERCHANT

54. NAME OF MANUFACTURER

55. NAME OF DISTRIBUTOR

56. NAME OF RETAILER

57. NAME OF WHOLESALE

58. NAME OF EXPORTER

59. NAME OF IMPORTER

60. NAME OF AGENT

61. NAME OF BROKER

62. NAME OF DEALER

63. NAME OF MERCHANT

64. NAME OF MANUFACTURER

65. NAME OF DISTRIBUTOR

66. NAME OF RETAILER

67. NAME OF WHOLESALE

68. NAME OF EXPORTER

69. NAME OF IMPORTER

70. NAME OF AGENT

71. NAME OF BROKER

72. NAME OF DEALER

73. NAME OF MERCHANT

74. NAME OF MANUFACTURER

75. NAME OF DISTRIBUTOR

76. NAME OF RETAILER

77. NAME OF WHOLESALE

78. NAME OF EXPORTER

79. NAME OF IMPORTER

80. NAME OF AGENT

81. NAME OF BROKER

82. NAME OF DEALER

83. NAME OF MERCHANT

84. NAME OF MANUFACTURER

85. NAME OF DISTRIBUTOR

86. NAME OF RETAILER

87. NAME OF WHOLESALE

88. NAME OF EXPORTER

89. NAME OF IMPORTER

90. NAME OF AGENT

91. NAME OF BROKER

92. NAME OF DEALER

93. NAME OF MERCHANT

94. NAME OF MANUFACTURER

95. NAME OF DISTRIBUTOR

96. NAME OF RETAILER

97. NAME OF WHOLESALE

98. NAME OF EXPORTER

99. NAME OF IMPORTER

100. NAME OF AGENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2444

CERTIFICATE OF DEATH

Reg. Dist. No. 03568

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>2 wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home Hospital</u>				d. STREET ADDRESS <u>Severna Park</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>C</u> Last <u>Hardy</u>				4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-15-91</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Harry C.</u>				14. MOTHER'S MAIDEN NAME <u>Ida Moots</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				17. INFORMANT <u>Family</u> Address <u>June</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. tracheitis + Bronchitis</u> DUE TO (b) <u>491X Bronchopneumonia +</u> DUE TO (c) <u>Chronic Pulmonary Fibrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>6 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>3/29/56</u> , 1956, that I last saw the deceased alive on <u>3/29/56</u> , 1956, and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city or town, state) <u>63 College Ave</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>				DATE SIGNED <u>3/29/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/2/56</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>			
22b. DATE THEREOF				22d. LOCATION (City, town, or county) <u>Baltimore</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>as above</u>				ADDRESS <u>as above</u>			
24a. REC'D BY REGISTRAR <u>APR 10 1956</u>				24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

BUREAU V. S.

APR 10 1956

RECEIVED

2484

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>Anne Arundel Co.</u> CITY OR TOWN <u>Elvaton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Waterford & Jumpers Hole Roads</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY OR TOWN <u>Elvaton</u> STREET ADDRESS <u>Waterford & Jumpers Hole Rds</u>			
3. NAME OF DECEASED (Type or Print) <u>JOSEPH H. HARRISON</u>				4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>29</u> (Year) <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 19, 1909</u>	9. AGE last birthday <u>46</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired 5 yrs</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Marie Kahl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-05-6287</u>		17. INFORMANT & ADDRESS <u>Mrs. Anna M. Horky (Daughter)</u> <u>P.O. Box 299 Millersville Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>157X IMMEDIATE CAUSE (A) Carcinoma of the Pancreas</u> <u>ANTECEDENT CAUSE(S) DUE TO with Metastasis to the</u> <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE Liver & Stomach</u> STATING UNDERLYING CAUSE LAST. DUE TO (C)				18. MEDICAL CERTIFICATION <u>INTERVAL BETWEEN ONSET AND DEATH 31/52</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>3/25</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of the Pancreas</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u> </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>3/29</u> , 19 <u>56</u> , to <u>3/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/29</u> , 19 <u>56</u> , and that death occurred at <u>12:05 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Alfred H. Anderson</u>				ADDRESS (Street, city, town, state) <u>44 Southgate Lane, Baltimore Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 2, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park Cem. Baltimore Md.</u>		LOCATION (City, town, or county) (State) <u> </u>	
24. REC'D BY REGISTRAR DATE <u>April 2, 1956</u>		REGISTRAR'S SIGNATURE <u>L. J. Schley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS, INC.</u> <u>Baltimore Md.</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
STATE OF NEW YORK
CERTIFICATE OF DEATH

FILE NO. 100

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. MARRIAGE DATE

8. MARRIAGE PLACE

9. OCCUPATION

10. CAUSE OF DEATH

11. PLACE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF CLERK

18. SIGNATURE OF JURY

19. SIGNATURE OF JUDGE

20. SIGNATURE OF SHERIFF

21. SIGNATURE OF CORONER

22. SIGNATURE OF DISTRICT ATTORNEY

23. SIGNATURE OF COUNTY CLERK

24. SIGNATURE OF TOWN CLERK

25. SIGNATURE OF VILLAGE CLERK

26. SIGNATURE OF POSTMASTER

27. SIGNATURE OF SCHOOL SUPERVISOR

28. SIGNATURE OF TOWN SUPERVISOR

29. SIGNATURE OF VILLAGE SUPERVISOR

30. SIGNATURE OF POSTMASTER

31. SIGNATURE OF SCHOOL SUPERVISOR

32. SIGNATURE OF TOWN SUPERVISOR

33. SIGNATURE OF VILLAGE SUPERVISOR

34. SIGNATURE OF POSTMASTER

35. SIGNATURE OF SCHOOL SUPERVISOR

36. SIGNATURE OF TOWN SUPERVISOR

37. SIGNATURE OF VILLAGE SUPERVISOR

38. SIGNATURE OF POSTMASTER

39. SIGNATURE OF SCHOOL SUPERVISOR

40. SIGNATURE OF TOWN SUPERVISOR

41. SIGNATURE OF VILLAGE SUPERVISOR

42. SIGNATURE OF POSTMASTER

43. SIGNATURE OF SCHOOL SUPERVISOR

BUREAU V. S.

APR 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2485

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore Md.</u> COUNTY <u>ANNE Arundel</u> City <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>13 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gilbert</u> Middle <u>O</u> Last <u>HERARDON</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>47</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Adron Herndon</u>		14. MOTHER'S MAIDEN NAME <u>Ruby B Hamlin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia - Hanging</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanging</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1220</u> <u>am.</u> <u>3/31/56</u> p. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f. (City or town) (County) (State) <u>ARCO MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. L. Linhardt</u>		DATE SIGNED <u>3/31/56</u>	
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/5/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	22d. LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. O. Wilson</u>		24. REC'D BY REGISTRAR DATE <u>APR 9 1956</u>	
ADDRESS <u>1000 Brantley Ave.</u>		REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. S.

APR 9 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2486 CERTIFICATE OF DEATH

02462

Reg. Dist. No. 24

Item 9 Film G195 4-13-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>A. A.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>LOMBARDEE BEACH</u>		<u>9 MONTHS</u>		TOWN <u>LOMBARDEE BEACH</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>LOMBARDEE CIRCLE</u>				STREET ADDRESS (If rural give location) <u>LOMBARDEE CIRCLE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EDGAR</u> (Middle) <u>CLAUSON</u> (Last) <u>HIRES</u>				(Month) <u>3</u> (Day) <u>23</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>8/23/82</u>	<u>73</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>MAINTENANCE</u>		<u>HOSPITAL</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>ISRAEL CLAUSON</u>				<u>SARAH T. ROWE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>215-05-5666</u>		<u>MRS E.C. HIRES - SAME</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>155X</u>				<u>6 months</u>			
IMMEDIATE CAUSE (A)				<u>Carcinoma Gall Bladder</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>10 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 19 55</u> , to <u>3/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/21</u> , 19 <u>56</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>G. Brady Smith</u>				ADDRESS (Street, city, town, state) <u>Riviera Beach, Md.</u>		DATE SIGNED <u>3/23/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/26/56</u>		<u>Baltimore Cem.</u>		<u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>MAR 27 1956</u>		<u>L. G. Sealba</u>		<u>John C. Miller Inc.</u>		<u>2431 E. Oliver St.</u>	

CERTIFICATE OF DEATH

1956

NOT FOR

1. PLACE OF DEATH

2. MANNER OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. DATE OF DEATH

6. NAME OF DECEASED

7. SEX AND AGE

8. OCCUPATION

9. MARITAL STATUS

10. MEDICAL HISTORY

11. CAUSE OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF CORONER

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF CLERK

17. SIGNATURE OF OFFICIAL

18. SIGNATURE OF OFFICIAL

BUREAU V. S.

MAR 27 1956

RECEIVED

RECEIVED
DEPARTMENT OF HEALTH - BALTIMORE, MD
MARCH 27 1956
BUREAU V. S.
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02463

2445

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>512 Burnside St.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>M</u> Last <u>HODEK</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>6</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 11, 1883</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank J. CYACH</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Nemec</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs J. Stuart Whelan Sr., Daughter, same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>570.5 Intestinal obstruction</u> DUE TO (b) <u>Stenosis at ileocecal valve</u> DUE TO (c) <u>Stenosis at ileocecal valve</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple liver abscesses</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>March 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 6</u> , 19 <u>56</u> , and that death occurred at <u>10:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John Hedeman</u> M.D.			
PHYSICIAN'S NAME (Type) <u>John Hedeman MD</u>		<u>90 Cathedral Street, Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 10, 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don L. Hopping Jr.</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>March 9, 56</u>	
24b. REGISTRAR'S SIGNATURE <u>U. Daniel</u>			

CERTIFICATE OF DEATH

MISSOURI STATE DEPARTMENT OF HEALTH - COLUMBIA, MO.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	

RECEIVED
MAR 12 1956
BUREAU V. 3

1

02464

2487

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ferndale, Glen Burnie</u>		LENGTH OF STAY (in this place) <u>31 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale, Glen Burnie,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>113 Baltimore Ave. N.</u>				STREET ADDRESS (If rural give location) <u>113 Baltimore Ave N.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Grace</u>		(Middle) <u>Edna</u>		(Last) <u>Hollin</u>		(Month) (Day) (Year) <u>March 18, 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 4, 1892</u>	9. AGE last birthday <u>63</u> Yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Winfree E. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Florence Joyner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>William Hollin, same as 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Cronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Quodanul Mose</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 5, 1956</u> to <u>March 18, 1956</u> , that I last saw the deceased alive on <u>March 16, 1956</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John J. Cleary M.D.</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/21/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>L. J. Seally</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Stukley</u> Address <u>Hopping & Kirkley, Glen Burnie, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MAR 22 1956

CERTIFICATE OF DEATH

Keep this form

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. SMITH		45		M		W		JAN 15 1910		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1234 E. MAIN ST.		Carpenter		High School		Married		JAN 20 1955		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		DATE OF LAST EXAMINATION		DATE OF DEATH	
Myocardial Infarction		Natural		3 weeks		None		JAN 15 1955		JAN 20 1955	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF DECEASED		DATE	
J. D. SMITH, M.D.		JAN 20 1955		J. D. SMITH, M.D.		JAN 20 1955					

BUREAU V. 1

MAR 22 1955

RECEIVED

NOTIFICATION
The undersigned hereby certifies that the foregoing is a true and correct copy of the original record of the death of the person named herein, as the same appears in the records of the State Department of Health, Baltimore, Maryland.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02465

2446 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>a a</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>a a</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10</u> <u>Baltimore</u>		LENGTH OF STAY (in this place) <u>6 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Birdsallville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>29 General Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Martha</u> (First) <u>Hopkins</u> (Middle) <u>Hopkins</u> (Last)				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>May 27 1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West River Ind</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Downs</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Nicks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Dan Hopkins, Birdsallville Ind</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
446X IMMEDIATE CAUSE (A) <u>nephrosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
<u>hypertension</u> (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychiatric, burn, at. bullet</u>						<u>1 1/2 wk</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Harwood</u> <u>AA</u> <u>md</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>2 23 56</u> P. M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>apparently fell</u>			
22. I hereby certify that I attended the deceased from <u>2/27/56</u> , to <u>3/4/56</u> , that I last saw the deceased alive on <u>3/4/56</u> , and that death occurred at <u>5:15 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shipley</u>				DATE SIGNED <u>3/5/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>West Zion</u>		LOCATION (City, town, or county) (State) <u>Lothian Ind</u> <u>md</u>	
24. REC'D BY REGISTRAR <u>Max</u>		REGISTRAR'S SIGNATURE <u>U. T. T. T.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard</u>		ADDRESS <u>Liberty, Liberty Ind</u>	
DATE <u>Mar. 5 1956</u>							

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2488

CERTIFICATE OF DEATH

02466

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>6yrs. 5mos. 15days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>9 Taylor Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>Howard</u> (Middle) <u>Howard</u> (Last)				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>15</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>5/10/12</u>	9. AGE last birthday <u>43</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Atterbury Howard</u>				14. MOTHER'S MAIDEN NAME <u>Alvera Howard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>520X</u> IMMEDIATE CAUSE (A) <u>Respiratory Insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Spontaneous pneumothorax with coexisting Lung disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u> </u>				19b. MAJOR FINDINGS OF OPERATION <u> </u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> </u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u> </u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>	
22. I hereby certify that I attended the deceased from <u>9/29</u>, 19 <u>49</u>, to <u>3/15</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>3/14</u>, 19 <u>56</u>, and that death occurred at <u>4:45a</u> M., from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict, M.D.</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/15/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-18-56</u>		NAME OF CEMETERY OR CREMATORY <u>Hope Chapel</u>		LOCATION (City, town, or county) (State) <u>Edgewater, Md</u>	
24. REC'D BY REGISTRAR <u> </u>		REGISTRAR'S SIGNATURE <u>26. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, D. Annapolis, Md</u>			
DATE <u>MAR 19 1956</u>							

CERTIFICATE OF DEATH

08168

State of Maryland

1. Name of deceased: *John Doe*

2. Date of death: *Jan 15, 1956*

3. Place of death: *Home*

4. Cause of death: *Heart Disease*

5. Age at death: *65*

6. Sex: *Male*

7. Race: *White*

8. Occupation: *Teacher*

9. Marital status: *Married*

10. Usual residence: *123 Main St, Baltimore, Md.*

11. Date of birth: *Jan 1, 1891*

12. Signature of physician: *[Signature]*

13. Signature of registrar: *[Signature]*

14. Date of registration: *Jan 16, 1956*

15. Place of registration: *Baltimore, Md.*

16. Name of hospital: *None*

17. Name of attending physician: *Dr. J. K. Smith*

18. Name of funeral home: *None*

19. Name of next of kin: *John Doe, Jr.*

20. Name of informant: *John Doe, Jr.*

21. Name of informant's address: *123 Main St, Baltimore, Md.*

22. Name of informant's occupation: *Teacher*

23. Name of informant's telephone: *None*

24. Name of informant's date of birth: *Jan 1, 1920*

25. Name of informant's sex: *Male*

26. Name of informant's race: *White*

27. Name of informant's marital status: *Married*

28. Name of informant's usual residence: *123 Main St, Baltimore, Md.*

29. Name of informant's occupation: *Teacher*

30. Name of informant's date of birth: *Jan 1, 1920*

31. Name of informant's sex: *Male*

32. Name of informant's race: *White*

33. Name of informant's marital status: *Married*

34. Name of informant's usual residence: *123 Main St, Baltimore, Md.*

35. Name of informant's occupation: *Teacher*

36. Name of informant's date of birth: *Jan 1, 1920*

37. Name of informant's sex: *Male*

38. Name of informant's race: *White*

39. Name of informant's marital status: *Married*

40. Name of informant's usual residence: *123 Main St, Baltimore, Md.*

41. Name of informant's occupation: *Teacher*

42. Name of informant's date of birth: *Jan 1, 1920*

43. Name of informant's sex: *Male*

44. Name of informant's race: *White*

45. Name of informant's marital status: *Married*

46. Name of informant's usual residence: *123 Main St, Baltimore, Md.*

47. Name of informant's occupation: *Teacher*

48. Name of informant's date of birth: *Jan 1, 1920*

49. Name of informant's sex: *Male*

50. Name of informant's race: *White*

51. Name of informant's marital status: *Married*

52. Name of informant's usual residence: *123 Main St, Baltimore, Md.*

53. Name of informant's occupation: *Teacher*

54. Name of informant's date of birth: *Jan 1, 1920*

55. Name of informant's sex: *Male*

56. Name of informant's race: *White*

57. Name of informant's marital status: *Married*

58. Name of informant's usual residence: *123 Main St, Baltimore, Md.*

59. Name of informant's occupation: *Teacher*

60. Name of informant's date of birth: *Jan 1, 1920*

61. Name of informant's sex: *Male*

62. Name of informant's race: *White*

63. Name of informant's marital status: *Married*

64. Name of informant's usual residence: *123 Main St, Baltimore, Md.*

65. Name of informant's occupation: *Teacher*

66. Name of informant's date of birth: *Jan 1, 1920*

67. Name of informant's sex: *Male*

68. Name of informant's race: *White*

69. Name of informant's marital status: *Married*

70. Name of informant's usual residence: *123 Main St, Baltimore, Md.*

71. Name of informant's occupation: *Teacher*

72. Name of informant's date of birth: *Jan 1, 1920*

73. Name of informant's sex: *Male*

74. Name of informant's race: *White*

75. Name of informant's marital status: *Married*

76. Name of informant's usual residence: *123 Main St, Baltimore, Md.*

77. Name of informant's occupation: *Teacher*

78. Name of informant's date of birth: *Jan 1, 1920*

79. Name of informant's sex: *Male*

80. Name of informant's race: *White*

81. Name of informant's marital status: *Married*

82. Name of informant's usual residence: *123 Main St, Baltimore, Md.*

83. Name of informant's occupation: *Teacher*

84. Name of informant's date of birth: *Jan 1, 1920*

85. Name of informant's sex: *Male*

86. Name of informant's race: *White*

87. Name of informant's marital status: *Married*

88. Name of informant's usual residence: *123 Main St, Baltimore, Md.*

BUREAU V. 2

1956

18 MAR 19

RECEIVED

PHOTO COPY

THIS IS A COPY OF THE ORIGINAL RECORD OF DEATH. IT IS NOT A SUBSTITUTE FOR THE ORIGINAL RECORD. THE ORIGINAL RECORD IS THE ONLY COPY OF THE RECORD THAT IS KEPT IN THE OFFICE OF THE REGISTRAR. THE ORIGINAL RECORD IS THE ONLY COPY OF THE RECORD THAT IS KEPT IN THE OFFICE OF THE REGISTRAR. THE ORIGINAL RECORD IS THE ONLY COPY OF THE RECORD THAT IS KEPT IN THE OFFICE OF THE REGISTRAR.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2447

CERTIFICATE OF DEATH

Reg. Dist. No.

02467

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>				c. LENGTH OF STAY IN 1b <u>Edgewater</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>63 Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Woodland Beach</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIE LOUISE HUGHES</u>				4. DATE OF DEATH Month Day Year <u>March 9, 19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 1, 1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Food Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Arlington, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William H. Gamble</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pyne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-28-3516</u>		17. INFORMANT Address <u>Mr. Joseph F. Hughes- Husband- same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> <u>583x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatitis, cause undetermined</u> DUE TO (c) <u>Cancer</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6-10 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>2/9/56</u> , 19 <u>56</u> , to <u>3/9/56</u> , that I last saw the deceased alive on <u>3/9/56</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Frank Shipley</u> M.D. DATE SIGNED <u>3/10/56</u> PHYSICIAN'S NAME (Type) <u>Frank Shipley M.D.</u> <u>63 College Ave. Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 13, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Walkers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington County, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>March 12, 56</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>	

X

BUREAU V. S.

1955 14 MAR 1

RECEIVED

2448

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>A. A. Co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>48 College Creek Terrace</i>				d. STREET ADDRESS <i>48 College Creek Terrace</i>			
3. NAME OF DECEASED (Type or print) First <i>Henretta</i> Middle <i>Hutton</i> Last <i>Hutton</i>				4. DATE OF DEATH Month <i>3</i> Day <i>21</i> Year <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-17-1880</i>	9. AGE (In years lost birthday) yrs. <i>76</i>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Domestic</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Lloyd Banks</i>				14. MOTHER'S MAIDEN NAME <i>Mary Ann Banks</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>778</i>		17. INFORMANT <i>Wm Hutton - 48 C. Crk Terrace, Annapolis, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i> 434.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-7-56</i> , 19 <i>56</i> , to <i>3-21-56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>3-17-56</i> , 19 <i>56</i> , and that death occurred at <i>11:45</i> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>G. T. Allen</i> M.D. <i>62</i>				ADDRESS (Street, city or town, state) <i>Cathedral St</i>		DATE SIGNED <i>3-22-56</i>	
PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>				G. L. CATHEDRAL ST			
22a. BURIAL, CREMATION, OR DISPOSAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-24-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Drewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md</i>				ADDRESS <i>March 23, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18

BUREAU V. S.

MAR 27 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02469

2489

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Baltimore</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Crownsville</u>		<u>1 yr</u>		STREET ADDRESS <u>1124 Calhoun Street</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				Baltimore City 3401-4			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Marie</u> (Middle) <u>Jackson</u> (Last) <u>Jackson</u>				(Month) <u>3</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married (sep)</u>	8. DATE OF BIRTH <u>5/1/1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Unk</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute + Chronic Brain Syndrome</u>				<u>1 yr</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Brain Abscess</u>				<u>1 yr</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Left hemiplegia</u>							
19a. DATE OF OPERATION <u>1/13/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Brain Abscess</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/23</u> , 19 <u>55</u> , to <u>3/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/29</u> , 19 <u>56</u> , and that death occurred at <u>8:35</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Crownsville State Hospital</u>		DATE SIGNED <u>3/31/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>mt auburn</u>		LOCATION (City, town, or county) (State) <u>md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>1348 N. Calhoun St</u>	

CERTIFICATE OF DEATH

Decedent: *James H. Brown*
 Date of Birth: *1/1/1880*
 Place of Birth: *St. Louis, Mo.*
 Date of Death: *11/13/32*
 Place of Death: *St. Louis, Mo.*
 Cause of Death: *Heart + Chronic Brain Syndrome*
 Contributing Factors: *Brain Abscess*
 Physician: *Dr. J. H. Brown*
 Hospital: *St. Louis Hospital*
 Burial Place: *St. Louis, Mo.*
 Signature: *[Signature]*
 Date: *11/13/32*

BUREAU V. S.

1956 APR 2 1955

RECEIVED

This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.
 The certificate is to be filled out in duplicate, and the original is to be filed in the office of the Registrar, and the duplicate is to be filed in the office of the attending physician or the coroner.
 The certificate is to be filled out in English, and the name of the decedent is to be written in full.
 The date of death is to be written in full, and the place of death is to be written in full.
 The cause of death is to be written in full, and the contributing factors are to be written in full.
 The physician's name is to be written in full, and the hospital name is to be written in full.
 The burial place is to be written in full.
 The signature is to be written in full, and the date is to be written in full.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2449

CERTIFICATE OF DEATH

Reg. Dist. No.

02470

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>62 W. Washington St</u>		d. STREET ADDRESS <u>62 W. Washington St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Scott Johnson</u>		4. DATE OF DEATH Month Day Year <u>3 15 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1878</u>
9. AGE (In years last birthday) yrs. <u>77</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>77</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Naval Acad.</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Wesley Harris</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>— —</u>	
17. INFORMANT <u>Hillary Johnson - 62 Wash. St. - Annapolis, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the Sigmoid & Metastasis approx 14yr.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>MAR 15th</u>	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>54</u> , to <u>MAR 15th</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MAR 15th</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Faye W. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Cathedral St</u> DATE SIGNED <u>3-16-56</u>	
PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II - 108 Wash. St Anne Md</u>		24a. REC'D BY REGISTRAR <u>MAR 19 1956</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

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MAR 18 1956
BUREAU V. S.

U.S. DEPARTMENT OF HEALTH - BATHING 18

CERTIFICATE OF DEATH

1

1

02471

MARYLAND

STATE DEPARTMENT OF HEALTH

2490

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Vista</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MAGO Vista</u>	
TOWN <u>Box 708 - Cottage Drive</u>		TOWN <u>Arnold MD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>EDNA</u> (Middle) <u>Louise</u> (Last) <u>Kelley</u>		4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>24</u> (Year) <u>1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Housewife</u>	8. DATE OF BIRTH <u>14 April 1902</u> AGE last birthday <u>53</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred R. Roman</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Stickfus</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Husband EARL KELLY</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Myocardial INFarction

Antecedent cause(s) (b) Hypertensive C.V. Disease

(c) Gen. Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

3 mo.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
OF INJURY		

22. I hereby certify that I attended the deceased from Jan, 1956 to 24 March, 1956, that I last saw the deceasedalive on 23 March, 1956 and that death occurred at 10:45 A.M., from the causes and on the date stated above.

SIGNATURE <u>R. Halpin</u>	(Degree or title) <u>MD.</u>	ADDRESS <u>Severna Park Md</u>	DATE SIGNED <u>24 March 56</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>March 28, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Severna Park Cem.</u>	LOCATION (City, town, or county) <u>Balto., Md.</u>
DATE REC'D BY LOCAL REG. <u>March 26, 1956</u>	REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>	24. FUNERAL DIRECTOR <u>R. Halpin</u>	ADDRESS <u>Severna Park, Md.</u>

MARGIN RESERVED FOR BINDING

Handwritten text: NUC Vamp

X

RECEIVED
MAR 28 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02472

2491

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort GG Meade</u>		LENGTH OF STAY (in this place) <u>26 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Linthicum</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>403 E. Maple Road</u>			
3. NAME OF DECEASED (Type or Print) <u>JESSE W. KELLY</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>21</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 7, 1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin K. Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Clara Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>1942 to 1955</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Wife-Ella C. Kelly,</u> <u>403 E. Maple Rd., Linthicum, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
19a. IMMEDIATE CAUSE (A) <u>199.1 Malignant tumor in abdomen.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>approx 4 months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Wide spread involent of liver and other organs</u>							
(C) <u>Renal shut down following exploratory operation.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>13 March 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>Large tumor in liver area</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>26 January 19 56</u> , to <u>21 March 19 56</u> , that I last saw the deceased alive on <u>21 March 19 56</u> , and that death occurred at <u>1115</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert T. Jensen</u> ROBERT T. JENSEN, CAPT., MC M.D.				ADDRESS (Street, city, town, state) <u>Ft George G. Meade, Md.</u> DATE SIGNED <u>21 Mar 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>13-25-56</u>		NAME OF CEMETERY OR CREMATORY <u>Greensboro Cemetery</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Maryland</u>	
24. REC'D BY REGISTRAR <u>WILLIAM L. SAYLOR, 1/Lt MSC</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rawlings Funeral Home, Greensboro, Md.</u>		ADDRESS	
DATE <u>21 Mar 56</u>							

BUREAU V.

MAR 23 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02473

2492 CERTIFICATE OF DEATH

Items 11, 13, 14 FilmG195 4-17-56 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ANNE Arundel		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Crownsville		4 mos, 21 days		TOWN Dundalk		0353.2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) 211 Silas Point Rd.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Samuel (Middle) (Last) Major				(Month) March (Day) 30 (Year) 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Negro	Married	6-12-02	53 Yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		Columbia, S. C.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Ned Major				Narcissus Nebney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) Cerebro-vascular accident							
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NONE							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-9 , 19 55 , to 3-30 , 19 56 , that I last saw the deceased alive on 3-30 , 19 56 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		4-3-56		Arbutus		Arbutus	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
APR 5 1956		[Signature]		[Signature]		862 Madison	

RECEIVED

2493

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gambles</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gambles</u>	
OR (give nearest town) <u>Gambles</u>		OR <u>Gambles</u>	
TOWN <u>Gambles</u>		TOWN <u>Gambles</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>James</u> (Middle) <u>Samuel</u> (Last) <u>Marguoss</u>		(Month) <u>3-</u> (Day) <u>16-</u> (Year) <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug 15-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>75</u> yrs.	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13. FATHER'S NAME <u>Jim Marguoss</u>	14. MOTHER'S MAIDEN NAME <u>Mollie Birchhead</u>	11. PLACE OF BIRTH (State or foreign country) <u>Bundeland md</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No. <u>16</u>	17. INFORMANT AND ADDRESS <u>Geo Edw. Marguoss - Bundeland md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
199.7 Immediate cause	(a) Acute Cerebral Thrombosis	1 day
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the <u>underlying cause last</u> :	(b) Metastatic Carcinoma	1 year
	(c)	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?			
								Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE				PLACE (Home, farm, factory, street, OF office bldg., etc.)				(CITY OR TOWN)			
(Specify)				INJURY				(COUNTY)			
								(STATE)			
TIME (Month) (Day) (Year) (Hour)				INJURY OCCURRED				HOW DID INJURY OCCUR?			
OF				While at							
INJURY				Work <input type="checkbox"/> Not While							
				At work <input type="checkbox"/>							

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

March 16-56, and that death occurred at 4 P.m., from the causes and on the date stated above.

SIGNATURE _____ (Degree or title) _____ ADDRESS _____ DATE SIGNED _____

SIGNATURE _____ (Degree or title) _____ ADDRESS _____ DATE SIGNED _____

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial		3/19/56	Mt Harmony	Owings	Ind
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS	
3/17/56	[Signature]	W. H. Stulldins		Owings, Md	

3-2156

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 27 1952

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02475

2450 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY AA		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Annapolis		-		TOWN Annapolis			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital				STREET ADDRESS (If rural give location) U.S. Naval Hospital			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Baby Girl MC CARTHY				March 16 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
F	Cau		14 March 1956	- yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
-		-		Maryland		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles John MC CARTHY				Betty Jean THOMAS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
-		-		U.S. N. Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 759.3 ATELECTASIS WITH IMMATURITY # 762.5						INTERVAL BETWEEN ONSET AND DEATH 2 Days	
ANTECEDENT CAUSE(S) DUE TO (B) MALFORMATION OF THROAT ORGANS AND MAXILLA NEC # 759.3						2 Days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 14 March, 19 56, to 16 March, 19 56, that I last saw the deceased alive on 16 March, 19 56, and that death occurred at 2:15 PM, from the causes and on the date stated above.							
SIGNATURE E.R. PETERS, LCDR, MC, USN				DATE SIGNED ADDRESS (Street, city, town, state) U.S. Naval Hospital, Annapolis, Md. 3-19-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3-20-56		Naval Academy		Annapolis Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE March 19, 56		John M. Taylor Sons		Annapolis Md			

2051353311

05435

RECEIVED BY BUREAU OF HEALTH - ST. LOUIS, MO.

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Place of Birth

6. Race

7. Occupation

8. Cause of Death

9. Date of Death

10. Place of Death

11. Signature of Physician

12. Signature of Registrar

13. Signature of Coroner

14. Signature of Medical Examiner

15. Signature of Health Officer

16. Signature of Burial Officer

17. Signature of Undertaker

18. Signature of Cemetery

19. Signature of Funeral Home

20. Signature of Mortician

21. Signature of Embalmer

22. Signature of Crematorium

23. Signature of Burial Society

24. Signature of Cemetery Association

25. Signature of Funeral Home Association

26. Signature of Mortician Association

27. Signature of Embalmer Association

28. Signature of Crematorium Association

29. Signature of Burial Society Association

30. Signature of Cemetery Association

31. Signature of Funeral Home Association

32. Signature of Mortician Association

33. Signature of Embalmer Association

34. Signature of Crematorium Association

35. Signature of Burial Society Association

36. Signature of Cemetery Association

37. Signature of Funeral Home Association

38. Signature of Mortician Association

39. Signature of Embalmer Association

40. Signature of Crematorium Association

41. Signature of Burial Society Association

42. Signature of Cemetery Association

43. Signature of Funeral Home Association

44. Signature of Mortician Association

45. Signature of Embalmer Association

46. Signature of Crematorium Association

47. Signature of Burial Society Association

48. Signature of Cemetery Association

49. Signature of Funeral Home Association

50. Signature of Mortician Association

51. Signature of Embalmer Association

52. Signature of Crematorium Association

53. Signature of Burial Society Association

54. Signature of Cemetery Association

BUREAU V. S.

MAR 21 19

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2494

CERTIFICATE OF DEATH

02476

Reg. Dist. No. *22*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>ANNE ARUNDEL</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>ANNE ARUNDEL</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>SEVERN</i>		LENGTH OF STAY (in this place) <i>40 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>SEVERN</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>HIRAM</i> <i>Mc GINNIS</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>MARCH 20 1956</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>WID</i>	8. DATE OF BIRTH <i>JAN 24 1887</i>		9. AGE last birthday <i>69 yrs.</i>		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FOREMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BRICK PLANT</i>		11. BIRTHPLACE (State or foreign country) <i>VA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles McGinnis</i>				14. MOTHER'S MAIDEN NAME <i>Alice P. McGinnis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-05-1583</i>		17. INFORMANT & ADDRESS <i>McGinnis, Severn Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>CONGESTIVE HEART FAILURE</i>						<i>2 mo.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>ANGINA CORONARY INSUFFICIENCY</i>						<i>6 mo +</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>ARTERIO SCLEROTIC HEART DISEASE</i>						<i>2 yrs +</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>March 15, 1956</i> , to <i>March 20, 1956</i> , that I last saw the deceased alive on <i>March 19, 1956</i> , and that death occurred at <i>5:04 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>C. McInnis</i>				ADDRESS (Street, city, town, state) <i>Severn Md</i>		DATE SIGNED <i>3/20/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>March 23/56</i>		NAME OF CEMETERY OR CREMATORY <i>Friendship Cem.</i>		LOCATION (City, town, or county) (State) <i>Severn Md</i>	
24. REC'D BY REGISTRAR <i>Clara Haslop</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>R. J. Sings</i>		ADDRESS <i>Severn Md</i>	

MAR 25 1956
DATE

CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MEDICAL HISTORY

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. DATE OF DEATH

13. TIME OF DEATH

14. PLACE OF INTERMENT

15. NAME OF FUNERAL HOME

16. NAME OF MINISTER

17. NAME OF CHURCH

18. NAME OF CEMETERY

19. NAME OF BURIAL PLACE

20. NAME OF INTERMENT

21. NAME OF FUNERAL HOME

22. NAME OF MINISTER

23. NAME OF CHURCH

24. NAME OF CEMETERY

25. NAME OF BURIAL PLACE

26. NAME OF INTERMENT

27. NAME OF FUNERAL HOME

28. NAME OF MINISTER

29. NAME OF CHURCH

30. NAME OF CEMETERY

31. NAME OF BURIAL PLACE

32. NAME OF INTERMENT

33. NAME OF FUNERAL HOME

34. NAME OF MINISTER

35. NAME OF CHURCH

36. NAME OF CEMETERY

37. NAME OF BURIAL PLACE

38. NAME OF INTERMENT

39. NAME OF FUNERAL HOME

40. NAME OF MINISTER

41. NAME OF CHURCH

42. NAME OF CEMETERY

43. NAME OF BURIAL PLACE

44. NAME OF INTERMENT

45. NAME OF FUNERAL HOME

46. NAME OF MINISTER

47. NAME OF CHURCH

48. NAME OF CEMETERY

49. NAME OF BURIAL PLACE

50. NAME OF INTERMENT

51. NAME OF FUNERAL HOME

52. NAME OF MINISTER

53. NAME OF CHURCH

54. NAME OF CEMETERY

55. NAME OF BURIAL PLACE

56. NAME OF INTERMENT

RECEIVED

BUREAU V. S.

MAR 23 1956

RECEIVED

2451

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>780 N. Washington St.</u>				d. STREET ADDRESS <u>780 N. Washington St.</u>			
3. NAME OF DECEASED (Type or print) <u>MADRIE</u>				4. DATE OF DEATH <u>March 18 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John McHowan</u>				14. MOTHER'S MAIDEN NAME <u>Mary McHowan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Ray Holmes</u>				Address <u>780 N. Washington St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC Nephritis</u> 592X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>	
22d. LOCATION (City, town, or county) <u>Annapolis, Md.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>				ADDRESS <u>Annapolis, Md.</u>		24. REC'D BY REGISTRAR <u>March 20, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mr. J. French</u>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Page One, 11a

<p>1. Name of Deceased: <u>JOHN J. BROWN</u></p>		<p>2. Date of Death: <u>10-15-55</u></p>	
<p>3. Place of Death: <u>Home</u></p>		<p>4. Address: <u>1234 Main St., Baltimore, Md.</u></p>	
<p>5. Age: <u>45</u></p>		<p>6. Sex: <u>Male</u></p>	
<p>7. Race: <u>White</u></p>		<p>8. Occupation: <u>Engineer</u></p>	
<p>9. Cause of Death: <u>Myocardial Infarction</u></p>		<p>10. Manner of Death: <u>Natural</u></p>	
<p>11. Signature of Medical Examiner: <u>[Signature]</u></p>		<p>12. Date of Examination: <u>10-15-55</u></p>	
<p>13. Signature of Coroner: <u>[Signature]</u></p>		<p>14. Date of Certification: <u>10-15-55</u></p>	

BUREAU V. 3

MAR 22 1956

KLEIN V. 10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film G195 4-12-56

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02478

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <i>A.A. Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AAPO</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hernon Harbor</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hernon Harbor</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>James H. McQuay</i>		4. DATE OF DEATH <i>9 30 1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 31, 1885</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>Carpenter (rtd)</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Hanson McQuay</i>		14. MOTHER'S MAIDEN NAME <i>Sarah --</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Geneva Green - Box 42, Millersville, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Disseminated Tuberculosis - Pulerculosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/3/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Balto. Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Lickner & Sons - Balto 17 Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>4/3/56</i>		24b. REGISTRAR'S SIGNATURE <i>L. J. Adkins</i>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2452

CERTIFICATE OF DEATH

Reg. Dist. No. 21

02479

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>65 Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>908 Boucher Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELLEN</u> Last <u>MESSICK</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>20</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1879</u>		9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Dail</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss S. Elizabeth Messick- Daughter- same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral accident & hemiplegia eff.</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic cardiac vascular disease</u> DUE TO (c) <u>hypertension gen. arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 17, 1956</u> to <u>March 20, 1956</u> , that I last saw the deceased alive on <u>March 20, 1956</u> , and that death occurred at <u>3:10 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edith Rodler</u> M.D.				ADDRESS (Street, city or town, state) <u>45 Franklin St. Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Edith Rodler MD</u>				DATE SIGNED <u>3-23-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 23, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edwards Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>3-23-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. J. J. J.</u>			

BUREAU V. 8

MAR 27 1956

RECEIVED

02480

2496

CERTIFICATE OF DEATH

Reg. Dist. No. 24

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> MARYLAND				STATE <u>MD.</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena MD.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena MD.</u>			
TOWN <u>Pasadena MD.</u>				TOWN <u>Pasadena MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HASTINGS LANE</u>				STREET ADDRESS <u>HASTINGS LANE</u>			
<u>Edward Drive Pasadena</u>				<u>Edward Drive Pasadena</u>			
3. NAME OF DECEASED (Type or Print) <u>Laura Grace Middleton</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>April 14 1885</u>	
9. AGE last birthday <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Wilmington Del.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Frank Christopher</u>		14. MOTHER'S MAIDEN NAME <u>Clara Baldwin</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Daughter, Pasadena</u> <u>Alyne Fawthrop, MD.</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
18a. IMMEDIATE CAUSE (A) <u>581.0</u> <u>Circulatory Failure</u>				18b. ANTECEDENT CAUSE(S) DUE TO (B) <u>Cirrhosis of Liver</u>			
18c. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Ascites - Jaundice</u>				18d. DUE TO (C)			
19a. DATE OF OPERATION <u>None</u>				19b. MAJOR FINDINGS OF OPERATION			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				20d. TIME OF INJURY (Month) (Day) (Year) (Hour)			
20e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>key</u> 19 <u>55</u> to <u>27 March 56</u> that I last saw the deceased alive on <u>27 March 56</u> and that death occurred at <u>6 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Hahn</u>				ADDRESS (Street, city, town, state) <u>M.D. Severna Park Md</u>			
DATE SIGNED <u>27 March 56</u>				DATE SIGNED <u>27 March 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
24. REC'D BY REGISTRAR <u>APR 5 1956</u>		REGISTRAR'S SIGNATURE <u>L. J. Dellaby</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>		ADDRESS <u>4001 Ritchie Hwy</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2497 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02481

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 1y. and 6 m.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 116 Martha Rd. Glenwood				d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Evelynn Middle Mary Last Mister				4. DATE OF DEATH March 24th. Month March Day 24th. Year 1956			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/10/11	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 44 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Packer (ref.)		10b. KIND OF BUSINESS OR INDUSTRY Scheffield & Co.		11. BIRTHPLACE (State or foreign country) Brockton, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Bernard Lincoln				14. MOTHER'S MAIDEN NAME Eva Maheux			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Herbert Mister, (husband.) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 (a), stating the underlying cause last. DUE TO (c) 420.1						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/25/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Arington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Fort Meyer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Richard C. Singleton				ADDRESS Glen Burnie 14th.		24a. REC'D BY REGISTRAR 3-26-56	
				24b. REGISTRAR'S SIGNATURE L. J. Dealla			

STATE OF TEXAS
MEDICAL EXAMINER
CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH-BALTIMORE 13

RECEIVED
MAR 28 1956
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02482

2453

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Joseph Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>63 Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>NEIDA</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 17, 1880</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tailor</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Uniforme Company</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>					
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>63 Southgate Ave</u> <u>Mrs William Stallings, Daughter- Annapolis, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA.</u> <u>1999</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMATOSIS, PRIMARY UNKNOWN</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u> <u>6 mos</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY, 1955</u> to <u>MAR.</u> 19 <u>56</u> , that I last saw the deceased alive on <u>8 MARCH</u> 19 <u>56</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>41 Southgate Ave., Annapolis, Md.</u> <u>3/11/56</u>					
PHYSICIAN'S NAME (Type) <u>Edward S. Beck M.D.</u>		41 Southgate Ave., Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 12, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>ANNAPOLIS, MD</u>		24a. REC'D BY REGISTRAR DATE <u>3-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

3433

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	
13. Name of funeral home		14. Name of cemetery		15. Name of burial place	
16. Name of next of kin		17. Name of executor		18. Name of administrator	
19. Name of guardian		20. Name of trustee		21. Name of agent	
22. Name of agent		23. Name of agent		24. Name of agent	
25. Name of agent		26. Name of agent		27. Name of agent	
28. Name of agent		29. Name of agent		30. Name of agent	
31. Name of agent		32. Name of agent		33. Name of agent	
34. Name of agent		35. Name of agent		36. Name of agent	
37. Name of agent		38. Name of agent		39. Name of agent	
40. Name of agent		41. Name of agent		42. Name of agent	
43. Name of agent		44. Name of agent		45. Name of agent	
46. Name of agent		47. Name of agent		48. Name of agent	
49. Name of agent		50. Name of agent		51. Name of agent	
52. Name of agent		53. Name of agent		54. Name of agent	
55. Name of agent		56. Name of agent		57. Name of agent	
58. Name of agent		59. Name of agent		60. Name of agent	
61. Name of agent		62. Name of agent		63. Name of agent	
64. Name of agent		65. Name of agent		66. Name of agent	
67. Name of agent		68. Name of agent		69. Name of agent	
70. Name of agent		71. Name of agent		72. Name of agent	
73. Name of agent		74. Name of agent		75. Name of agent	
76. Name of agent		77. Name of agent		78. Name of agent	
79. Name of agent		80. Name of agent		81. Name of agent	
82. Name of agent		83. Name of agent		84. Name of agent	
85. Name of agent		86. Name of agent		87. Name of agent	
88. Name of agent		89. Name of agent		90. Name of agent	
91. Name of agent		92. Name of agent		93. Name of agent	
94. Name of agent		95. Name of agent		96. Name of agent	
97. Name of agent		98. Name of agent		99. Name of agent	
100. Name of agent		101. Name of agent		102. Name of agent	

BUREAU V. 2

MAR 14 1956

RECEIVED

DATE 3-14-56

2498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Severna Park</u>		c. LENGTH OF STAY IN 1b <u>20 y.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gov. Ritchie Highway, Earleigh Heights.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia Neilson</u>				4. DATE OF DEATH <u>3/22/56</u>		Month Day Year <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/84</u>		9. AGE (In years last birthday) <u>71 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>B.altimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Thomas F. Dempsey, Severna Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>RITCHIE HWY GLEN BURNIE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc 6009 HARBOR</u>				24a. REC'D BY REGISTRAR <u>DATE 3/27/56</u>			
				24b. REGISTRAR'S SIGNATURE <u>L. J. Hall</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED SEX AGE RACE BIRTH DATE BIRTH PLACE MARRIED OCCUPATION RESIDENCE DECEASED DATE DECEASED TIME DECEASED PLACE DECEASED CAUSE DECEASED MANNER DECEASED DISEASE DECEASED INJURY DECEASED POISON DECEASED OTHER		NAME OF PHYSICIAN NAME OF HOSPITAL NAME OF NURSE NAME OF CORONER NAME OF JURY NAME OF JUDGE NAME OF CLERK NAME OF SHERIFF NAME OF DEPUTY SHERIFF NAME OF CONSTABLE NAME OF TOWNSHIP CLERK NAME OF COUNTY CLERK NAME OF STATE CLERK NAME OF FEDERAL CLERK NAME OF MARSHAL NAME OF DEPUTY MARSHAL NAME OF SHERIFF NAME OF DEPUTY SHERIFF NAME OF CONSTABLE NAME OF TOWNSHIP CLERK NAME OF COUNTY CLERK NAME OF STATE CLERK NAME OF FEDERAL CLERK NAME OF MARSHAL NAME OF DEPUTY MARSHAL	
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RECEIVED
 MAR 27 1956
 BUREAU V. S.

2499

02484

Reg. Dist. No.

25

1. PLACE OF DEATH a. COUNTY <u>A. D. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. D. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>Owens</u> Middle <u>Owens</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-1878</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Washington Randall</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Randall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John Henry Owens - Harwood, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-15-56</u> , 19 <u>56</u> , to <u>3-1-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-27-56</u> , 19 <u>56</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u>		DATE SIGNED <u>6-2-56 Caldwell St</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		<u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-4-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chews Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Owensville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		ADDRESS <u>108 Wash. St. Annapolis, Md</u>	
24a. REC'D BY REGISTRAR <u>Mar. 6, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Caldwell Woodruff</u>	

2500

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Anne Arundel</u> MARYLAND			STATE <u>Same</u> COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Millersville</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Same</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>			STREET ADDRESS (If rural give location) <u>Same</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)		
<u>Rose Perino</u>			<u>March 13th. 1956</u>		
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>7/16/75</u>		9. AGE last birthday: <u>80</u> yrs.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Hungary, Europe</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Benjamin Deutsch</u>			14. MOTHER'S MAIDEN NAME: <u>?</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS: <u>Mrs. M. O'Connor, Glen Burnie, Md. (daughter)</u>		

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<u>Immediate cause</u> (a) <u>Cerebral Hemorrhage</u>				<u>3 months</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular Diseases</u>				<u>Over 3 m.</u>	
(c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/10/55</u> , 19....., to <u>3/13/56</u> , 19....., that I last saw the deceased alive on <u>3/7/56</u> , 19....., and that death occurred at <u>6.15 A.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Eustace F. Fancher</u>		Glen Burnie, Md.		DATE SIGNED <u>3/13/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)		
<u>Burial</u>	<u>March 15-56</u>	<u>New Cathedral</u>	<u>Fredrick Rd Baltimore Md</u>		
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS			
<u>March 15, 1956</u>	<u>E. M. Jones</u> (L. J. S. Alba)	<u>Bernard G. Fink Glen Burnie Md</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 19 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02487

2501 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>—</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort G. G. Meade, Md.</u>		LENGTH OF STAY (In this place) <u>9 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3Vo 1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>2907 Denham Circle</u>			
3. NAME OF DECEASED (Type or Print) <u>ALEXIS</u> (First) <u>POWELL</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>March 2</u> 19 <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1 March 1956</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Michael Powell, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Jane Alexander</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mother</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
762.5 IMMEDIATE CAUSE (A) <u>Atelectasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>						<u>1 day</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 1, 1956</u> , to <u>March 2, 1956</u> , that I last saw the deceased alive on <u>March 2, 1956</u> , and that death occurred at <u>8:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Herbert H. Needleman</u> M.D.				DATE SIGNED <u>2 March 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>3 March 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Removed to Medical Lab.</u>		LOCATION (City, town, or county) (State) <u>Ft GG Meade, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>2 March 1956</u> REGISTRAR'S SIGNATURE <u>W.L. Saylor, 1st Lt, MSC</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>none</u> ADDRESS			

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BUREAU V. S.

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02485

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Annapolis</u>		TOWN <u>Annapolis (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. S. General Hosp.</u>		STREET ADDRESS (If rural, give location) <u>Gambills, Md</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Dr. Mox.</u> (Middle) <u>Queen</u> (Last) <u>Queen</u>		(Month) <u>3</u> (Day) <u>23</u> (Year) <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>5-24-1944</u>
9. AGE last birthday: <u>11</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles Queen</u>		14. MOTHER'S MAIDEN NAME: <u>Pauline Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>Pauline Queen - Gambills, Md</u>	
17. INFORMANT & ADDRESS: <u>Pauline Queen - Gambills, Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		Interval
Immediate cause (a) <u>Fracture Skull - Fracture Left Arm -</u>		
Antecedent cause(s) (b) <u>Skull Fractures.</u>		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>8-12-56</u>		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>gun</u>)	21c. (City or town) (County) (State)
<u>Anne Arundel Co</u>	<u>MD</u>	<u>MD</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3 26 56 P M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Struck by auto</u>

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Thurman CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 3/24/56

DEPUTY MEDICAL EXAMINER ☒ M. D. ASSISTANT MEDICAL EXAM. 3/24/56

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-27-56</u>	NAME OF CEMETERY OR CREMATORY <u>Int. Tabor</u>	LOCATION (City, town, or county) (State) <u>Chesterfield, Md.</u>
DATE REC'D BY LOCAL REG. <u>3-27-56</u>	REGISTRAR'S SIGNATURE <u>Wm. Hedger</u>	24. FUNERAL DIRECTOR <u>William Beech</u>	ADDRESS <u>108 W. Wash. St. Annapolis, Md</u>

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8548

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
OFFICE OF THE ASSISTANT SECRETARY
WASHINGTON, D. C.

PLANT INDUSTRY REPORT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02488

2455

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bowie & Parker Ave.</i>				d. STREET ADDRESS <i>Bowie & Parker Ave.</i>			
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Queen</i> Last <i>Green</i>				4. DATE OF DEATH Month <i>3</i> Day <i>23</i> Year <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-3-1877</i>		9. AGE (In years last birthday) <i>79</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Rutland, md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Herbert Parker</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Brandford</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <i>John H. Green - Annapolis, md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO (b) <i>332X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-25-56</i> , 19, to <i>3-27-56</i> , 19, that I last saw the deceased alive on <i>3-25-56</i> , 19, and that death occurred at <i>11 P.</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A. T. Allen</i>				ADDRESS (Street, city or town, state) <i>62 Cochran</i> DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>				M.D. <i>CH + MEDICAL</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>3-30-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>4/2/1956</i> DATE	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF CHURCH OFFICIAL		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CEMETERY	
21. SIGNATURE OF HEALTH OFFICIAL		22. SIGNATURE OF DISTRICT CLERK		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF STATE CLERK	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF BURIAL OFFICIAL		28. SIGNATURE OF CHURCH OFFICIAL	
29. SIGNATURE OF FUNERAL HOME		30. SIGNATURE OF CEMETERY		31. SIGNATURE OF HEALTH OFFICIAL		32. SIGNATURE OF DISTRICT CLERK	
33. SIGNATURE OF COUNTY CLERK		34. SIGNATURE OF STATE CLERK		35. SIGNATURE OF DECEASED		36. SIGNATURE OF NEXT OF KIN	
37. SIGNATURE OF BURIAL OFFICIAL		38. SIGNATURE OF CHURCH OFFICIAL		39. SIGNATURE OF FUNERAL HOME		40. SIGNATURE OF CEMETERY	
41. SIGNATURE OF HEALTH OFFICIAL		42. SIGNATURE OF DISTRICT CLERK		43. SIGNATURE OF COUNTY CLERK		44. SIGNATURE OF STATE CLERK	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF NEXT OF KIN		47. SIGNATURE OF BURIAL OFFICIAL		48. SIGNATURE OF CHURCH OFFICIAL	
49. SIGNATURE OF FUNERAL HOME		50. SIGNATURE OF CEMETERY		51. SIGNATURE OF HEALTH OFFICIAL		52. SIGNATURE OF DISTRICT CLERK	
53. SIGNATURE OF COUNTY CLERK		54. SIGNATURE OF STATE CLERK		55. SIGNATURE OF DECEASED		56. SIGNATURE OF NEXT OF KIN	
57. SIGNATURE OF BURIAL OFFICIAL		58. SIGNATURE OF CHURCH OFFICIAL		59. SIGNATURE OF FUNERAL HOME		60. SIGNATURE OF CEMETERY	
61. SIGNATURE OF HEALTH OFFICIAL		62. SIGNATURE OF DISTRICT CLERK		63. SIGNATURE OF COUNTY CLERK		64. SIGNATURE OF STATE CLERK	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF BURIAL OFFICIAL		68. SIGNATURE OF CHURCH OFFICIAL	
69. SIGNATURE OF FUNERAL HOME		70. SIGNATURE OF CEMETERY		71. SIGNATURE OF HEALTH OFFICIAL		72. SIGNATURE OF DISTRICT CLERK	
73. SIGNATURE OF COUNTY CLERK		74. SIGNATURE OF STATE CLERK		75. SIGNATURE OF DECEASED		76. SIGNATURE OF NEXT OF KIN	
77. SIGNATURE OF BURIAL OFFICIAL		78. SIGNATURE OF CHURCH OFFICIAL		79. SIGNATURE OF FUNERAL HOME		80. SIGNATURE OF CEMETERY	
81. SIGNATURE OF HEALTH OFFICIAL		82. SIGNATURE OF DISTRICT CLERK		83. SIGNATURE OF COUNTY CLERK		84. SIGNATURE OF STATE CLERK	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF BURIAL OFFICIAL		88. SIGNATURE OF CHURCH OFFICIAL	
89. SIGNATURE OF FUNERAL HOME		90. SIGNATURE OF CEMETERY		91. SIGNATURE OF HEALTH OFFICIAL		92. SIGNATURE OF DISTRICT CLERK	
93. SIGNATURE OF COUNTY CLERK		94. SIGNATURE OF STATE CLERK		95. SIGNATURE OF DECEASED		96. SIGNATURE OF NEXT OF KIN	
97. SIGNATURE OF BURIAL OFFICIAL		98. SIGNATURE OF CHURCH OFFICIAL		99. SIGNATURE OF FUNERAL HOME		100. SIGNATURE OF CEMETERY	

BUREAU V. S.

APR 3 1936

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02489

2502

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ft. George G. Meade, Md.</u>		<u>6 months</u>		TOWN <u>Fort George G. Meade</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>1826 Patton Drive Apt. C.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>RITA</u>		(Middle) <u>MARIE</u>		(Last) <u>RALPH</u>		(Month) <u>March</u> (Day) <u>14</u> (Year) <u>1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday		10. IF UNDER 1 YEAR
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>10 March 1956</u>		<u>4</u> yrs.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Sullivan Ralph</u>				<u>Mabel Rita Stensrud</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>752X</u> IMMEDIATE CAUSE (A) <u>Hydrocephalic spina bifida, Meningocele</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10 March 1956</u> to <u>14 March 1956</u>, that I last saw the deceased alive on <u>14 March 1956</u>, and that death occurred at <u>8:45 P.</u> M, from the causes and on the date stated above.							
SIGNATURE		DATE SIGNED		ADDRESS (Street, city, town, state)			
<u>HERBERT L. NEEDLEMAN 1ST LT, MC.</u>		<u>15 March 1956</u>		<u>Fort Geo. G. Meade, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/16/56</u>		<u>Arlington National Cemetery</u>		<u>Arlington Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE 15 March 56</u>		<u>W.L.SAYLOR, 1ST LT, MSC</u>		<u>F. Gasch's Sons</u>		<u>Hyattsville, Md.</u>	

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02490

2503

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Rock Creek, Pasadena</u>				OR TOWN <u>Rock Creek, Pasadena, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Water Oak Pt,</u>				STREET ADDRESS (If rural give location) <u>Water Oak Pt.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u> (Middle) <u>F.</u> (Last) <u>SAUERS</u>				(Month) <u>March</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 13, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel owner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Penna</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A?</u>
13. FATHER'S NAME <u>William Sauers</u>				14. MOTHER'S MAIDEN NAME <u>Catherine ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Mrs. Bessie L. Sauers, Pasadena, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Carcinoma of the esophagus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>September 19, 1949</u> , to <u>March 9, 1956</u> , that I last saw the deceased alive on <u>March 8, 1956</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>R.M. McLaughlin</u> ADDRESS (Street, city, town, state) <u>M.D. RFD Box 442 Pasadena Md. Mar. 9 1956</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 12, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Parkville, Md.</u>	
24. REC'D BY REGISTRAR <u>Mar. 12, 1956</u>		REGISTRAR'S SIGNATURE <u>L. J. Sedberry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road</u> ADDRESS			

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BUREAU V. S.

MAR 12 1953

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02491

2504

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Md.</i> COUNTY <i>A. A.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Galesville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Galesville</i>	
OR TOWN <i>Galesville</i>		LENGTH OF STAY (in this place) <i>life</i>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (First) (Middle) (Last) <i>Ella May Sievert</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Mar 25 1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Sept 26, 1877</i>	9. AGE last birthday <i>78</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country) <i>Sudley, Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Edwin Nutwood</i>				14. MOTHER'S MAIDEN NAME <i>Mary Jane Minnick</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Graham Sievert, 8445 Side, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Cardiac arrest</i>				INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Congestive Failure</i>				<i>3 weeks</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arteriosclerotic heart disease</i>				<i>? years -</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Diabetes Mellitus</i>				<i>25 years</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <i>M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>January 19</i> to <i>Mar 25</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>25 Mar 19 56</i> , and that death occurred at <i>8:30 P.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>E. J. Endrich, M.D.</i>				ADDRESS (Street, city, town, state) <i>Shady Side, Maryland</i> DATE SIGNED <i>3/28/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3/28/56</i>		NAME OF CEMETERY OR CREMATORY <i>Lawyer</i>		LOCATION (City, town, or county) (State) <i>Galesville, Md.</i>	
24. REC'D BY REGISTRAR <i>April 2, 1956</i>		REGISTRAR'S SIGNATURE <i>Edward Collier</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard O. Hardisty</i>		ADDRESS	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02492

2456

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>		c. LENGTH OF STAY IN 1b <i>10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10</i>		e. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>T. Jeffrey</i> First Middle Last		4. DATE OF DEATH Month <i>3</i> Day <i>12</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Gold</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-31-56</i>
9. AGE (In years lost birthday) yrs. <i>16</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Fredrick Smith</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Allen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>- - -</i>	
17. INFORMANT <i>Ruth Allen - Annapolis, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>754.4 Congenital Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>6 hrs</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/11</i> , 1956, to <i>3/12</i> , 1956, that I last saw the deceased alive on <i>3/11</i> , 1956, and that death occurred at <i>2 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore H. Johnson</i> M.D.		DATE SIGNED <i>37 Calvert Street</i>	
PHYSICIAN'S NAME (Type) <i>THEODORE H. JOHNSON M.D.</i>		<i>Annapolis, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-13-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Broad Neck</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		24a. REC'D BY REGISTRAR <i>3-14-56</i>	
ADDRESS <i>108 W. Wash. St Annapolis, Md 20631</i>		24b. REGISTRAR'S SIGNATURE <i>J. J. J. J.</i>	

MAR 16 1956

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2457

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>D.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp</u>				d. STREET ADDRESS <u>211 Chester Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Snowden</u> Last <u>Snowden</u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 11, 1860</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A. A. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>A. A. Co.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>John Carroll A. Mt. View, N. Y.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Nephrosclerosis</u> (c) <u>Generalized Atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/16</u> , 19 <u>56</u> , to <u>3/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/19</u> , 19 <u>56</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>376 Calvert Street</u>			
DATE SIGNED <u>3/23/56</u>				PHYSICIAN'S NAME (Type) <u>Dr. THEODORE H. JOHNSON</u> <u>Annapolis, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bronck Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Annie A. Johnson</u> ADDRESS <u>Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u>Mar 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 27 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02494

2575

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>aa</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>aa</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arva</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Riverview Nursing Home</u>		STREET ADDRESS (If rural give location) <u>1008 Jackson</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>Amie Laurie Springfield</u>		3-15-1956	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1-17-1871</u>
9. AGE last birthday <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Benedict Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Hiram Constance</u>		14. MOTHER'S MAIDEN NAME <u>Laurie Hurley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS <u>George W. Springfield</u>		(2)	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardio-Vascular-</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Renal disease & decompensation</u>		2 Wks.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility & senile dementia</u>		Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/13</u> , 19 <u>56</u> , to <u>3/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>56</u> , and that death occurred at <u>8:15</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Maurice Klawans</u> M.D.		ADDRESS (Street, city, town, state) <u>Annapolis Md</u>	
DATE SIGNED <u>3/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-15-56</u>	NAME OF CEMETERY OR CREMATORY <u>St Marys</u>	LOCATION (City, town, or county) <u>Annapolis Md</u>
24. REC'D BY REGISTRAR <u>JO - U. Council</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>	ADDRESS <u>Annapolis Md</u>
DATE <u>3-19-1956</u>			

02481

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

DATE OF DEATH

TO WHOM THE DEATH IS REPORTED

NAME

AGE

SEX

RACE

PLACE OF DEATH

DATE

TIME

CAUSE OF DEATH

BUREAU V. S.

MAR 21 1956

RECEIVED

RECEIVED

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IN THE COUNTY WHERE THE DEATH OCCURRED. IT IS TO BE RETURNED TO THE COUNTY CLERK OF THE COUNTY WHERE THE DEATH OCCURRED, WHO SHALL FILE IT IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

2458

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) e. INSTITUTION <u>A. A. General Hosp.</u>			d. STREET ADDRESS <u>Rt 4, Box 712</u>		
3. NAME OF DECEASED (Type or print) <u>Carrie</u> First <u>Stanbury</u> Middle Last			4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-5-1886</u>	9. AGE (In years lost birthday) <u>69</u> yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles Fleetwood</u>			14. MOTHER'S MAIDEN NAME <u>Elsie Snowden</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or, if unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>Mr Perry Stanbury - Annapolis, Md.</u>		
17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ateriovascular Nephrosclerosis</u> 5 yrs (c) <u>Hypertensive Cardio-Vascular Disease</u> 5 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 86 days</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>3/5</u> , 19 <u>56</u> , to <u>3/21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/21</u> , 19 <u>56</u> , and that death occurred at <u>12:57 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.			ADDRESS (Street, city or town, state) <u>37 Calver T. Street</u> DATE SIGNED <u>3/21</u>		
PHYSICIAN'S NAME (Type) <u>THEODORE H. JOHNSON MD</u>			ANNA POLIS, MD <u>3/21/56</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-25-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Broad Neck</u>		22d. LOCATION (City, town, or county) (State) <u>Skidmore, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Annapolis, Md.</u> ADDRESS			24a. REC'D BY REGISTRAR <u>22 1956</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Wm. J. Luchie</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2528

[Faint, mostly illegible handwritten text and printed form fields are visible across the page. The form includes sections for personal information, cause of death, and medical history.]

BUREAU V. B.

MAR 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02496

2506

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arrundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arrundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G Meade</u>				c. LENGTH OF STAY IN 1b <u>Jessup, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U S Army Hospital</u>				d. STREET ADDRESS <u>/</u>			
3. NAME OF DECEASED (Type or print) First <u>Patsy</u> Middle <u>L</u> Last <u>Straub</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25, 1936</u>	
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Belfonte, Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Grant Boone</u>				14. MOTHER'S MAIDEN NAME <u>Mae Weaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute rheumatic myocarditis</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs.</u> <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>31 March</u> , 19 <u>56</u> , to <u>31 March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>31 March</u> , 19 <u>56</u> , and that death occurred at <u>5:00 P</u> .M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Myron J. Myers</u>				M.D. <u>USAH, Ft Geo G Meade, Md.</u> <u>31 March 56</u>			
PHYSICIAN'S NAME (Type) <u>Myron J. Myers, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4 April 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Romola Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Center Co. Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Kelchner</u>				ADDRESS <u>Jersey Shore, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>2 Apr 56</u>	
24b. REGISTRAR'S SIGNATURE <u>Harry C. Caw</u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

APR 5 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02497

2507

CERTIFICATE OF DEATH

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Central Ave.</u>				d. STREET ADDRESS <u>Central Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MANUEL</u> Middle <u>IRVING</u> Last <u>SUITE</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>28</u> Year <u>19 56</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 27, 1879</u>		
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer tenant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Davidsonville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James W. Suite</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Walker</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-36-2863</u>		17. INFORMANT Address <u>Mrs Blanche Purdy Suite, Wife- Same As # 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 26, 1956</u> , to <u>March 28, 1956</u> , that I last saw the deceased alive on <u>March 28, 1956</u> , and that death occurred at <u>9 P. M.</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D.				ADDRESS (Street, city or town, state) <u>Lothian, Md</u> DATE SIGNED <u>3/31/56</u>				
PHYSICIAN'S NAME (Type) <u>Emily H. Wilson MD</u>				Lothian, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 31, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Davidsonville, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>ANNAPOLIS, MARYLAND</u>				24a. REC'D BY REGISTRAR <u>Mar. 31-56</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Smith</u>		

APR 3 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02498

2508

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale (Glen Burnie P.O.)</u>	
TOWN <u>FERNDALE</u>		LENGTH OF STAY (In this place) <u>years</u>		TOWN <u>Ferndale</u>		TOWN <u>Ferndale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>103 Oakleigh Ave</u>				STREET ADDRESS (If rural give location) <u>103 Oakleigh Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>CLARENCE</u> (First) <u>THEIS</u> (Middle) <u>ST.</u> (Last)				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>24</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 21, 1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab Driver (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>San Lab Co</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.C., New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Theis</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Forbes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-05-0149</u>		17. INFORMANT & ADDRESS <u>Mrs. Viola Theis</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Coronary artery occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary artery disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic heart disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 1955</u> to <u>March 24, 1956</u>, that I last saw the deceased alive on <u>Feb. 1956</u>, and that death occurred at <u>5:11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph Theis</u>		102 Balto - Ann of 2nd. A.E.		ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u>		DATE SIGNED <u>3/24/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 26, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>		LOCATION (City, town, or county) (State) <u>Baltoy Md.</u>	
24. REC'D BY REGISTRAR <u>3-26-56</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Kingston</u>		ADDRESS <u>Glen Burnie, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

CERTIFICATE OF DEATH

Rev. Code 1956

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF CHURCH

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF BURIAL PLACE

19. SIGNATURE OF INTERMENT

20. SIGNATURE OF RECORDS

21. SIGNATURE OF VITALS

22. SIGNATURE OF DEATH

23. SIGNATURE OF BIRTH

24. SIGNATURE OF MARRIAGE

25. SIGNATURE OF DIVORCE

26. SIGNATURE OF SEPARATION

27. SIGNATURE OF ADULTERY

28. SIGNATURE OF FORNICATION

29. SIGNATURE OF SODOMY

30. SIGNATURE OF OBSCENITY

31. SIGNATURE OF CRUELTY

32. SIGNATURE OF INDECENCY

33. SIGNATURE OF DISSENT

34. SIGNATURE OF CONTEMPT

35. SIGNATURE OF OBSTRUCTION

36. SIGNATURE OF VIOLATION

37. SIGNATURE OF BREACH

38. SIGNATURE OF MISFEASANCE

39. SIGNATURE OF NONFEASANCE

40. SIGNATURE OF NEGLIGENCE

41. SIGNATURE OF MISDEMEANOR

42. SIGNATURE OF FELONY

43. SIGNATURE OF CRIME

44. SIGNATURE OF TRESPASS

45. SIGNATURE OF VANDALISM

46. SIGNATURE OF ARSON

47. SIGNATURE OF BURGLARY

48. SIGNATURE OF LARCENY

49. SIGNATURE OF RECEIVING STOLEN GOODS

50. SIGNATURE OF HARBORING A FUGITIVE

51. SIGNATURE OF OBSTRUCTION OF JUSTICE

52. SIGNATURE OF PERJURY

53. SIGNATURE OF SUBORNATION OF PERJURY

54. SIGNATURE OF FALSE EVIDENCE

55. SIGNATURE OF OBSTRUCTION OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02499

2459

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo, Md</u>	
d. NAME OF HOSPITAL (Net in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>			d. STREET ADDRESS <u>Mayo, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Hershel</u> First <u>Thomas</u> Middle <u>Thomas</u> Last			4. DATE OF DEATH <u>3</u> Month <u>29</u> Day <u>1956</u> Year		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-1902</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mayo, Md</u>
13. FATHER'S NAME <u>Emory Thomas</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
14. MOTHER'S MAIDEN NAME <u>Emma Smith</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>218-09-9076</u>			17. INFORMANT <u>Sarah Thomas-Mayo, Md</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Acute Congestive Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal Disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>3-10-56</u> , 19 <u>56</u> , to <u>3-29-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-29-56</u> , 19 <u>56</u> , and that death occurred at <u>1:25</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>A. T. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Cathedral St</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-1-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mark</u>	
22d. LOCATION (City, town, or county) <u>Mayo</u>		(State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		ADDRESS <u>Annapolis, Md</u>		24a. REC'D BY REGISTRAR <u>4-2-1956</u>	
24b. REGISTRAR'S SIGNATURE <u>U. Daniel</u>					

APR 3 1954

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02500

2539

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Md.</u> COUNTY <u>B. A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>GLENBURNIE</u>		LENGTH OF STAY (in this place)		TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR</u>				STREET ADDRESS (If rural give location) <u>2006 St. Paul St.</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY L. TILLINGHAST</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>12</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Jan. 11, 1878</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady (rt'd)</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Greene Tillinghast</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Gray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. June M. Plitt-1627 Clarkson St.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROSIS,</u>							
ANTECEDENT CAUSE(S) DUE TO <u>GENERAL</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5:00 P.M.</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph T. ...</u>				DATE SIGNED <u>3/12/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>3/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>North Cedar Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Frankford, Phila., Pd.</u>	
24. REC'D BY REGISTRAR <u>3/13/56</u>		REGISTRAR'S SIGNATURE <u>...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>...</u> ADDRESS <u>...</u>			

02508

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CORONER

21. SIGNATURE OF JURY

22. SIGNATURE OF JUDGE

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF CORONER

25. SIGNATURE OF JURY

26. SIGNATURE OF JUDGE

27. SIGNATURE OF SHERIFF

28. SIGNATURE OF CORONER

29. SIGNATURE OF JURY

30. SIGNATURE OF JUDGE

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF CORONER

33. SIGNATURE OF JURY

34. SIGNATURE OF JUDGE

35. SIGNATURE OF SHERIFF

36. SIGNATURE OF CORONER

37. SIGNATURE OF JURY

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41. SIGNATURE OF JURY

42. SIGNATURE OF JUDGE

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45. SIGNATURE OF JURY

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81. SIGNATURE OF JURY

82. SIGNATURE OF JUDGE

83. SIGNATURE OF SHERIFF

84. SIGNATURE OF CORONER

BUREAU V. S.

MAR 14 1956

RECEIVED

02501

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2510

CERTIFICATE OF DEATH

Reg. Dist. No. 25

Item 12, Film 194 3-16-56 et

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Baltimore</u> COUNTY <u>Pratt</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ind.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Ind.</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>106 11th - Gay Brooklyn</u>		STREET ADDRESS (If rural, give location) <u>106 11th St Brooklyn Park</u>	
3. NAME OF DECEASED (Type or Print) <u>Alexander</u>	(First) <u>Ulatowski</u>	(Middle)	(Last)
4. DATE OF DEATH <u>March 9</u>	(Month)	(Day)	(Year) <u>1956</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1891</u>
9. AGE last birthday <u>65</u> yrs.	If under 1 year Months	If under 24 hrs. Hours	Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John</u>		14. MOTHER'S MAIDEN NAME <u>Ulatowski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Edward Ulatowski Son</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422 Immediate cause (a) <u>Arteriosclerotic C. Disease</u>		6 yrs.
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/9, 1956, to March 9, 1956, that I last saw the deceased alive on 3/6, 1956, and that death occurred at 9 A. m., from the causes and on the date stated above.

SIGNATURE Edmund B. Schley M.D. ADDRESS 4700 Pennington Ave. DATE SIGNED 3/9/56

23. BURIAL, CREMATION, REMOVAL (Specify) Buried DATE THEREOF March 14/56 NAME OF CEMETERY OR CREMATORY Holy Cross LOCATION (City, town, or county) (State) Baltimore

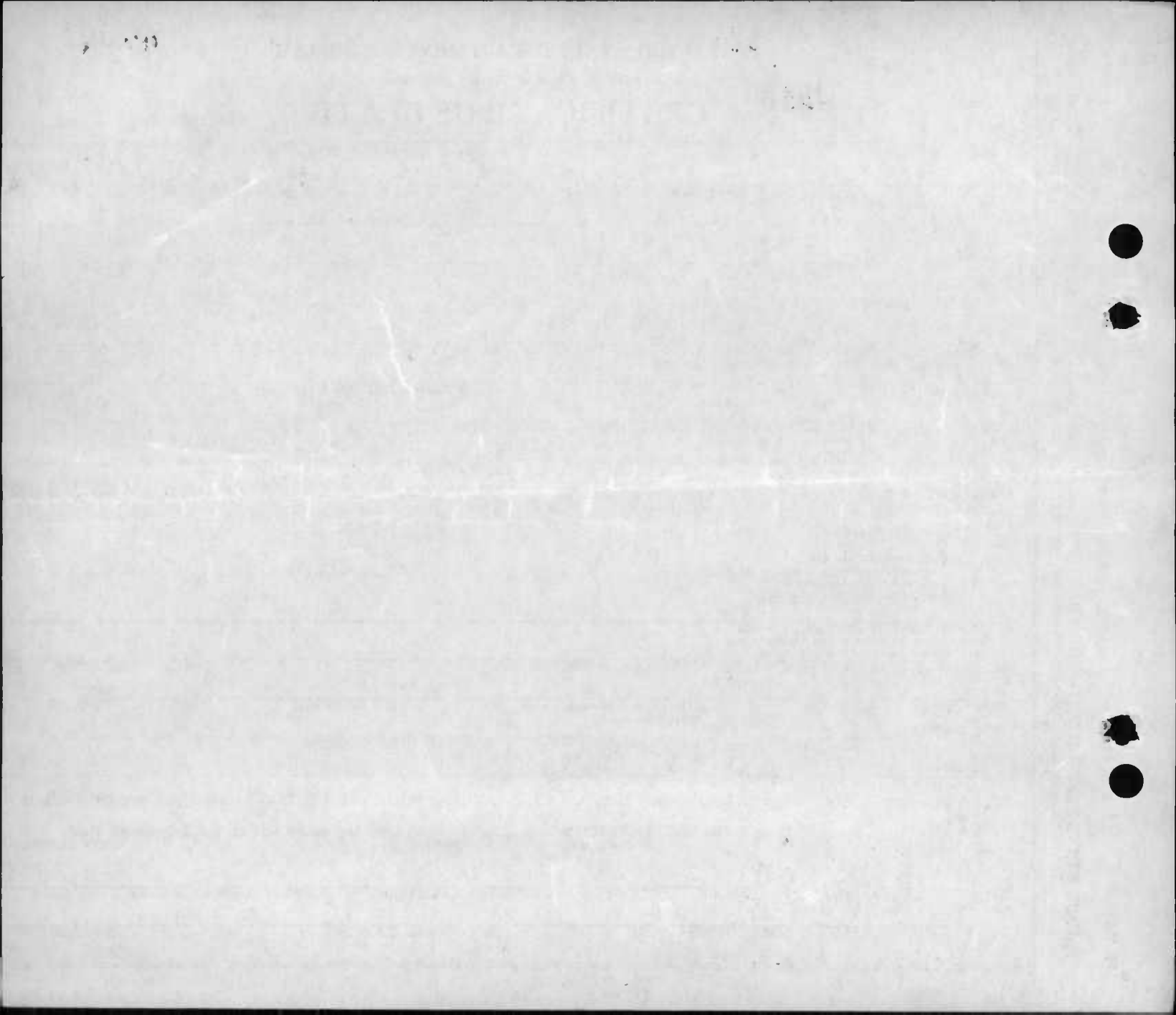
DATE REC'D BY LOCAL REG. 3-12-56 REGISTRAR'S SIGNATURE A. W. Hedrich 24. FUNERAL DIRECTOR Fred W. Ozagowski ADDRESS 1930 Eastern Ave

dmr.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02502

2511 CERTIFICATE OF DEATH

Reg. Dist. No. 116 ²⁸

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
<u>Crownsville</u>		<u>4yrs. 5mos. 4days</u>		<u>Route #1 - East New Market</u>		<u>09X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Crownsville State Hospital</u>				<u>East New Market</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE (at birth)	
<u>Anderson</u>				<u>3</u> <u>18</u> <u>19</u> <u>56</u>		<u>77</u> yrs.	
6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE (at birth)	
<u>Male</u>		<u>Negro</u>		<u>3/12/79</u>		<u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Shipyard worker</u>				<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Luke Ward</u>				<u>Mary Elizabeth Bryan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
570.5 IMMEDIATE CAUSE (A) <u>Toxemia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Intestinal obstruction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/14</u> , 19 <u>51</u> , to <u>3/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/18</u> , 19 <u>56</u> , and that death occurred at <u>8:45pm</u> , from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>L. Benedict, M. D.</u>				<u>Salem, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/25/56</u>		<u>Salem Cemetery</u>		<u>Salem, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>March 22, 1956</u>		<u>John H. D. D.</u>		<u>H. M. Sullivan Jr.</u>		<u>Cambridge Md</u>	
		<u>Dr. M. Joyner</u>					

DECLASSIFICATION

1
This document contains information which is exempt from release under E.O. 11652, paragraph 1, and E.O. 11652, paragraph 2, and is being released to the public under E.O. 11652, paragraph 3.

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. 2.

MAR 23 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2512

CERTIFICATE OF DEATH

02503

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>3mos.20 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u>		<u>3601.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>2207 Cecil Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>Benjamin</u> (First) <u>Williams</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> <u>20</u> <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/29/08</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Charles Williams</u>				14. MOTHER'S MAIDEN NAME <u>Cecille Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
163X IMMEDIATE CAUSE (A) <u>Hypostatic Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Known to us Since 11/28/55</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastatic sarcoma of Lungs</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/28</u> , 19 <u>55</u> , to <u>3/20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/19</u> , 19 <u>56</u> , and that death occurred at <u>7:40AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>(L. Benedict, M. D.)</u> M.D. <u>Crownsville, Md.</u>		DATE SIGNED <u>3/20/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>3/24/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR DATE <u>March 23, 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles G. Cooper</u>		ADDRESS <u>512 Carrollton Ave.</u>	

CERTIFICATE OF DEATH

1955

DATE OF DEATH

NAME OF DECEASED

MARYLAND

STATE OF MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

WITNESSES

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

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BUREAU V. S.

MAR 27 1955

RECEIVED

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2460

CERTIFICATE OF DEATH

02504

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>122 Spa View Ave.</u>		d. STREET ADDRESS <u>122 Spa View Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Eliza</u> Last <u>Willis</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Easton Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Patchett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hopkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Howard A. Kinkart</u> Address <u>(2)</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-16-</u> , 19 <u>55</u> , to <u>3-6-</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3-3-</u> , 19 <u>56</u> , and that death occurred at <u>8:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		ADDRESS (Street, city or town, State) <u>185 Prince Georges St. Annapolis, Md.</u> DATE SIGNED <u>3-8-56</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-8-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemt</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>DATE 3-8-56</u>	24b. REGISTRAR'S SIGNATURE <u>J. J. Douch</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED